



Health Reform Update – Weeks of June 12 and 19, 2017

CONGRESS

Latest ACA repeal and replace bill draws protests from both conservative and moderate Senators

Senate leaders released a draft this week of their proposed changes to the House-passed bill that would repeal and replace key provisions for the Affordable Care Act (ACA).

The working group submitted their Better Care Reconciliation Act (BCRA) to the Congressional Budget Office (CBO) before allowing it to be publicly released. The draft makes several changes intended to garner the support of moderate Senators, especially those from states expanding Medicaid, largely by making premium tax credits more generous than the House version (H.R. 1628) and extending the phase-out of the Medicaid expansion.

H.R. 1628 initially sought to make up to \$4,000 in tax credits available per year and base them only on age (see Update for Week of May 8th), compared to the ACA which made them available on a sliding-scale for those earning 100-400 percent of the federal poverty level (FPL). The latest Senate bill would allow them be both income and age-based and make them available for those below 100 percent of FPL who are not Medicaid-eligible in their state. However, the upper threshold would fall from 400 to 350 percent of FPL (or about \$86,000 for a family of four).

The phase-out of the Medicaid expansion would be extended until 2025. In exchange for that concession to pro-expansion Senators, the growth rate for the Medicaid per capita spending caps that the bill would impose would be more restricted.

These two changes resulted in an immediate revolt from more conservative Senators, who viewed the tax credits as a “new entitlement” and are seeking a prompt termination of the Medicaid expansion. At least four of them led by Rand Paul (R-KY) pledged not to vote for the current bill, which can afford no more than two defections.

However, an equal number of moderates such as Susan Collins (R-ME) and Rob Portman (R-OH) were alarmed about the Medicaid provisions, especially the tighter per capita caps, which will increase Medicaid budget shortfalls for states that do not dramatically cut Medicaid benefits or payment rates. According to the Urban Institute, the tighter caps will reduce federal payments by another \$467 billion, on top of the more than \$800 billion estimated by CBO. Other concerns included the flexibility that the BCRA would give states to require that Medicaid enrollees re-apply every six months.

Each faction was also worried that out-of-pocket (OOP) costs will climb dramatically for those previously eligible for ACA subsidies, both from the lower eligibility thresholds (see above) and from the BCRA's decrease in the actuarial value (AV) of the “benchmark” silver-tier plan on which the credits are calculated. Under the ACA, the “benchmark” plan was required to cover 70 percent of costs on average, which the BCRA would lower to only 58 percent, which would equate to an annual deductible of about \$7,000. This would cause OOP to climb by roughly 68 percent, including a nearly 30 percent increase in average deductibles.

These consumers would also face a “double whammy” as the affordability threshold would be increased for those above 100 percent of FPL, so that a plan would have to cost them more before they become subsidy-eligible. The increase varies by income and age so that a plan would now have to cost someone age 50-59 earning 300-350 percent of poverty at least 15.8 percent of their income to be subsidy-eligible, compared to only 10.5 percent under the ACA.



Under the BCRA, \$2 billion in grant funding will be available to states that seek federal waivers to opt-out of the essential benefit packages under the ACA (and again offer low-premium “junk” coverage)—a key provision in the House bill that was very popular with conservatives. States could also still opt-out of annual OOP limits or the restrictions on how much insurers can vary premiums based on age (which increases from 300 percent under the ACA to 500 percent). However, Senate leaders removed the controversial provision from H.R. 1628 that would let states also opt-out of the community rating requirement under the ACA, which prohibits insurers from varying premiums based on pre-existing conditions. That provision was opposed by several moderate Senators leery of weakening the protection against pre-existing condition discrimination—by far the most popular part of the ACA.

The BCRA repeals most ACA taxes with the exception of the “Cadillac” tax on high-cost health plans that is not yet in effect (it would be further delayed until 2025.) Penalties for the individual and employer mandates under the ACA would also be eliminated. The cost-sharing reductions (CSR) for those earning 100-250 percent of FPL would be fully-funded until 2019, in order to help stabilize ACA Marketplaces, after which they would likewise be repealed.

Majority Leader Mitch McConnell (R) insists that a vote will be held next week despite concerns from conservatives like Ron Johnson (R-WI) that such a fast track will not allow ample time to study the bill, get input from constituents, and make necessary changes. However, the BCRA has yet to be scored by the CBO nor have final determinations been made by the Senate parliamentarian on whether provisions such as the EHB waivers can pass with only a simple majority through budget reconciliation. An adverse decision from either could create significant obstacles for the Senate to quickly proceed.

House passes three limited measures related to ACA tax credits

The House advanced three measures this week that are intended to be part of the overall Republican strategy to repeal and replace the Affordable Care Act (ACA) (see above)

The first bill (H.R. 2372) would amend the American Health Care Act (AHCA) passed last month by the House (see Update for Week of May 8th) to allow veterans eligible for but not enrolled in Department of Veterans Affairs coverage to be eligible for AHCA premium tax credits in the existing Affordable Care Act (ACA) Marketplaces. It passed on a voice vote.

The second bill (H.R. 2579) would permit AHCA tax credits to be also used for purchasing COBRA continuation coverage. It received the support of 41 Democrats.

The third bill (H.R. 2581) would require confirmation of eligibility and residency status by the Social Security Administration or Department of Homeland Security for individuals seeking premium tax credits. It received the support of seven Democrats.

ACA repeal would cause more than 900,000 job losses in less than a decade

A new analysis released last week by The Commonwealth Fund predicts that the American Health Care Act (AHCA) passed by the House would 924,000 job losses nationwide by 2026.

Researchers highlighted the Congressional Budget Office projection that the AHCA would cause roughly 23 million in coverage losses by 2026 (see Update for Weeks of May 15th and 22nd) to project that the reductions in support for health insurance would immediately result in the loss of 24,000 jobs in the health care sector by 2018. This trend would accelerate as the Medicaid expansion under the ACA is phased-out, which was a major driver of job growth in expansion states.

Roughly three-quarters of all job losses by 2026 would occur in the health care sector. The study points to the fact that the national economy has experienced a record number of consecutive quarters of



job growth that commenced with the passage of the ACA, with the majority of the job growth occurring in health care.

According to the study, the loss of those jobs would reduce gross state products by \$93 billion by 2026, with business output falling by roughly \$148 billion.

Democrats introduce bill to bring back reinsurance in individual market

Senate Democrats introduced legislation last week (S.1354) that would permanently restore the reinsurance payments under the Affordable Care Act (ACA), which compensated Marketplace insurers for exceptional claims.

The reinsurance and risk corridor payments under the ACA expired at the end of 2016, leading several major insurers to either exit the Marketplaces for 2017 or dramatically increase premiums. According to the American Academy of Actuaries, of the 22 percent average increase in pre-subsidy premiums for 2017 Marketplace, nearly a third were directly attributable to the lack of reinsurance payments, which had been credited with reducing Marketplace premiums by ten percent from 2014-2016.

Senators Tom Carper (D-DE) and Tim Kaine (D-VA) are the lead sponsors of the legislation and cited the increased premiums as the reason the reinsurance program should have been made permanent, as it was under the Medicare Part D drug program that a Republican Congress created in 2003. They also pointed to the fact that Republican legislatures in both Alaska and Minnesota have already enacted legislation that created state-funded reinsurance payments for Marketplace insurers following the expiration of the ACA program—and at least ten other states are considering similar measures (see Update for Weeks of May 29th and June 5th).

S.1354 would provide federal funding to cover 80 percent of claims from \$50,000 to \$500,000, starting next year, with the same level of support through 2020. Beginning in 2021, the reinsurance program would start at \$100,000. They would be available to all ACA-compliant qualified health plans in the individual market (which excludes grandfathered or transitional plans).

Under the ACA, the reinsurance payments were funded by an assessment on all commercial insurers, not just individual health plan or Marketplace insurers. Reinsurance payments started at \$45,000 for the first two years then moved up to \$90,000. However, while it covered 100 percent of insurer costs from \$45,000-\$250,000 in 2014, it only covered 55 percent in 2015 and 50 percent of the higher threshold in 2016.

FEDERAL AGENCIES

CMS actuary confirms AHCA will dramatically increase consumer out-of-pocket costs

The Office of the Actuary for the Centers for Medicare and Medicaid Services (CMS) projected last week that consumers will pay an average of 27 percent more for health insurance over the next decade under the version of the American Health Care Act (AHCA) passed by the House (see Update for Week of May 8th).

The analysis used different assumptions than the Congressional Budget Office (CBO) score of the legislation (H.R. 1628). That cost estimate predicted that while average premiums would slightly decrease over the next decade (after an initial spike), out-of-pocket costs for those aged 50-64 would increase by up to 847 percent (see Update for Weeks of May 15th and 22nd). However, the CMS Actuary found that average premiums would actually rise by about five percent over the next decade, while average out-of-pocket costs would jump across-the-board by more than 61 percent.



As with CBO, the CMS Actuary did conclude that the higher age groups would be most adversely impacted by the AHCA, resulting in about a 12 percent decline in enrollment among those age 50-59, rising to 16 percent for age 60 or more. The Actuary also agreed with CBO that provisions allowing states to opt-out of essential health benefits, community rating, and other Affordable Care Act (ACA) consumer protections "could result in a deteriorating or possibly failing market" for individual health insurance, depending on how states chose to implement such a waiver.

However, the most significant difference between CMS and CBO projections relate to coverage losses and Medicaid spending. The Actuary predicts that ten million fewer Americans would lose health insurance coverage as a result of the AHCA (13 million by 2026 compared to 23 million). It also estimates a far lower cut in federal Medicaid spending (\$383 billion by 2026 compared to \$834 billion).

STATES

Start-up insurer to enter underserved Marketplace regions

Oscar Health announced this week that it was expanding its Marketplace coverage for 2018 in an effort to take advantage of opportunities created by the departure of some of the nation's largest insurers.

The insurance company started in 2012 by the brother of President Trump's son-in-law bills itself as a narrow network alternative to larger health insurers and initially targeted only urban centers in the Marketplaces for California, New Jersey, New York, and Texas. It had roughly 130,000 enrollees across all four states before losing about \$180 million on Marketplace business for 2015 and 2016. As a result, it stopped offering coverage in the Dallas-Fort Worth region and withdrew entirely from the New Jersey Marketplace for 2017 (see Update for Week of August 22, 2016).

However, Oscar has decided to return to 14 counties in the New Jersey Marketplace for 2018 as well as expand into the Nashville region in Tennessee and five counties in northeast Ohio, two states where several counties had been left unserved. In addition, it will expand its coverage area in Los Angeles and serve the Austin region in Texas (it already operates in San Antonio).

Oscar's chief executive officer stated that the company has elected to expand instead of contract during a time of great "uncertainty" due to their belief that Congress will stabilize the Marketplaces once the "dust is settled". He insisted that "there are simply too many lives at stake for representatives in Washington, D.C. not to do what's right for the people."

The expansion by Oscar is in sharp contrast to Anthem Blue Cross Blue Shield's decision this week to abandon the Marketplaces for Indiana and Wisconsin next year. That follows their announcement last week that it would exit the Ohio Marketplace, leaving 20 counties unserved (see Update for Weeks of May 29th and June 5th).

Delaware

Lone Marketplace insurer seeks 33 percent rate hike due to expected ACA repeal

Highmark Blue Cross Blue Shield has agreed to participate in the Affordable Care Act (ACA) Marketplace for 2018 but is seeking a 33.6 percent average premium increase in order to compensate for the expected loss of the law's cost-sharing reductions and individual mandate.

Department of Insurance officials stressed that the increase will not apply outside the Marketplace and may be adjusted after their review by "independent actuaries."

Delaware is one of seven states that currently have only one insurer in their Marketplace, following Aetna's decision to drop out for 2018.



District of Columbia

Marketplace board extends open enrollment period beyond federal limit

The executive board for the DC Health Benefit Exchange Authority (HBX) unanimously adopted the recommendation from its Standing Advisory Board to extend the open enrollment period beyond the six weeks set by federal regulation.

The Centers for Medicare and Medicaid Services (CMS) shortened the annual enrollment period for federally-facilitated Marketplaces to only six weeks starting with the 2018 period (see Update for Week of May 8th). It will now run only from November 1st to December 15th of each year.

However, state-based Marketplaces like the District of Columbia remain free to set their own open enrollment period and the board elected to stay with the three-month period that was in place for 2017 (which ran from November 1st to January 31st). It will do so by creating a special enrollment period that runs for the six weeks following the expiration of the federal period (effectively creating an extension from December 16th through January 31st). Covered California made a similar decision last month (see Update for Weeks of May 15th and 22nd).

Florida

Both Marketplaces to remain robust for 2018

The Office of Insurance Regulation (OIR) announced this week that six insurers are planning to sell individual health plans in the Affordable Care Act (ACA) Marketplace for 2018.

As expected, Florida Blue will continue to offer coverage statewide (and remain the only insurer for most rural counties), though it was warned that it will hike premiums by roughly 20 percent midyear should the ACA cost-sharing reductions not be fully-funded (see Update for Weeks of May 29th and June 5th). Molina Healthcare will also participate, with a similar caveat. The remaining four are Celtic Insurance, Florida Health Care Plan, Health First Commercial Plans, and Health Options.

According to OIR, the six insurers will also sell individual coverage outside of the Marketplace, where they will be joined by three others. The nine are seeking an average rate hike of 17.8 percent.

Florida is one of few states that also has a robust small group Marketplace under the ACA. For 2018, 14 insurers will participate in that Marketplace with a proposed average rate hike of 9.2 percent.

Iowa

Federal waiver would create reinsurance program to stabilize ACA Marketplace

Insurance Commissioner Doug Ommen (R) released the details of a proposed federal waiver that would create a temporary “stopgap” program to stabilize the Affordable Care Act (ACA) Marketplace.

Medica is the only insurer that currently plans to offer Marketplace coverage statewide for 2018. However, it is seeking a 43.5 percent average premium increase to compensate for the expected loss of the ACA cost-sharing reductions and individual mandate, and indicated that it may still withdraw if the increase is not approved. Aetna and Wellmark Blue Cross and Blue Shield previously announced they would exit the Marketplace next year. However, Wellmark has stated that they would re-enter the Marketplace if the federal waiver was granted.

Medica and Wellmark were heavily involved in the development of the proposed waiver, which would use an additional \$80 million in federal reinsurance payments to compensate insurers for 85 percent of a subscriber's annual health care costs between \$100,000 and \$3 million (and 100 percent thereafter). Wellmark cited the example of a subscriber with hemophilia, claiming that her \$1 million per



month in treatment costs were driving-up premiums for the rest of the relatively small risk pool following the expiration of the ACA's reinsurance program at the end of 2016.

The reinsurance program would follow the example of Alaska and Minnesota, which are currently seeking federal Section 1332 waivers for state-funded reinsurance models they have already implemented (see Update for Week of May 8th). Roughly ten other states are considering seeking similar waivers, which are available under the ACA starting last January for states experimenting with coverage models that provide comparable coverage to the ACA without increasing the federal deficit (see Update for Weeks of May 29th and June 5th). However, the Trump Administration is expected to broaden these restrictions if Congress does not do so under their current ACA repeal and replace bill (see above).

The waiver would also restructure the ACA's tax credits so that they are available to non-Marketplace consumers, as well as those earning slightly above the current maximum limit at 400 percent of the federal poverty level. In addition, the tax credits would be increased for young adults and lowered for older adults, in an effort to get presumably healthier and less costly subscribers into the risk pool.

All individual market carriers would be able to offer a single, standardized plan comparable to the silver-tier level plan under the ACA. It would include all ten essential health benefit packages required by the ACA and be the only plan available for those currently enrolled in grandfather or transitional health plans that were allowed not to comply with the ACA.

Michigan

Insurers must submit two sets of proposed rates to account for potential loss of ACA subsidies

The Department of Insurance and Financial Services issued a June 1st bulletin notifying insurers that it must submit two sets of rate filings if it wishes to participate in the Affordable Care Act (ACA) Marketplace for 2018.

The first proposed rate filings assumes that the Trump Administration will fully-fund the cost-sharing reductions (CSRs) provided by the ACA through the full plan year. The second set allows insurers to increase rates in the event the Administration does not guarantee the availability of the CSRs by August 16th.

Last month, the Trump Administration delayed its decision on whether to continue the Obama Administration's appeal of an adverse court decision invalidating the CSRs (see Update for Week of May 8th). The court is now not expected to hear that case before late September at the earliest. However, leading Congressional Republicans have insisted that the CSRs need to be guaranteed prior to that date in order to remove the uncertainty that they acknowledge is causing major insurers to exit the Marketplaces or hike premiums (see Update for Weeks of May 29th and June 5th).

Blue Cross Blue Shield of Michigan is the only insurer to thus far file proposed 2018 premiums. Their filing would increase premiums by an average of 26.9 percent if the CSRs are provided or a record 31.7 percent if they are not. This is a far lower discrepancy than the nearly 20 percent increase that major insurers such as Anthem, Florida Blue, and Molina pledged they would seek if the CSRs were terminated, based on studies from Kaiser Family Foundation and other groups showing such an increase would be necessary to offset the loss of the CSRs (see Update for Week of May 15th and 22nd).

Arkansas, California, and New Mexico are three of the other states that are allowing insurers to submit two sets of rates. California also set a mid-August deadline, however insurers in that state are allowed to factor in the Administration's lack of enforcement for the ACA individual mandate in addition to the loss of CSRs (see Update for Weeks of May 29th and June 5th).



Nevada

Governor vetoes bill that would give all residents opportunity to purchase Medicaid coverage

Governor Brian Sandoval (R) vetoed legislation late last week that would have let residents purchase Medicaid-equivalent coverage through Nevada Health Link (see Update for Weeks of May 29th and June 5th), including those receiving premium and cost-sharing subsidies under the Affordable Care Act (ACA).

The Governor waited until the last minute to veto A.B. 374, which was opposed by most members of his party and would have required an unlikely federal waiver from the Trump Administration. He insisted that he needed to take a “deep dive” into its policy implications given the potential repeal and replacement of the ACA (see above). Despite applauding the “creativity” of bill sponsor Assemblyman Mike Sprinkle (D), he ultimately decided that the bill would be premature, lacked a “factual foundation”, and “could produce more uncertainty to an already fragile healthcare market.”

Governor Sandoval also vetoed A.B. 408, which would have required Medicaid to cover certain preventive health services and codified some of the most popular provisions of the ACA into state law in the event they are repealed by Congress (see above). This includes requirements that insurers cover everyone regardless of health status, not vary premiums based on health status, and allow young adults up to age 26 to remain on their parents’ group coverage

Despite the vetoes, Governor Sandoval remains opposed to Congressional efforts to repeal key provisions of the ACA including the Medicaid expansion. He was one of three Republican governors (along with Charlie Baker of Massachusetts and John Kasich of Ohio) who signed onto a letter last week (with four Democratic governors) urging Congress to take a more “bipartisan approach” that would protect “vulnerable” populations, which includes preserving the expansion and guaranteeing the law’s cost-sharing subsidies will continue to be fully-funded (see Update for Weeks of May 29th and June 5th).

Aetna reverses decision to leave all ACA Marketplaces for 2018

The Division of Insurance confirmed last week that Aetna has submitted proposed rate filings to participate in Nevada Health Link, despite its earlier announcement that it would exit all Affordable Care Act (ACA) Marketplaces for 2018 (see Update for Week of May 8th).

Aetna will be joined by Silver Summit (a subsidiary of Centene), which decided earlier this month to enter the Marketplace for Nevada and two other states where major insurers had exited (see Update for Weeks of May 29th and June 5th). Anthem Blue Cross Blue Shield, Health Plan of Nevada (UnitedHealthcare), and Prominence are all expected to return after participating in 2017.

The entry of Aetna and Silver Summit is attributed to Nevada’s new process of awarding contracts for Marketplace insurers. Previously, insurers could only participate in Medicaid managed care if they also offered a silver and gold plan in the Marketplace. That requirement was credited with keeping UnitedHealthcare in the Marketplace, even though they have exited the Marketplaces for every other states except New York.

However, Nevada eliminated that requirement in 2017 in favor of a process that awards additional points to Marketplace bidders that also participate in Medicaid managed care. They also are no longer limited the number of Medicaid managed care organizations (MCOs) that can participate in the Marketplace to two. As a result, all four Medicaid MCOs plan to participate in the Marketplace for 2018 (Aetna, Anthem, Silver Summit, and UnitedHealthcare).

Nevada is also the only state in the country where individual non-Marketplace plans are available year-round. However, it does impose a three-month waiting period for those who enroll outside of open enrollment and do not have a qualifying event that would trigger a special enrollment period.



New Mexico

All insurers will remain in ACA Marketplace, offer statewide coverage

All four of the insurers in the New Mexico Health Insurance Exchange (NMHIX) submitted proposed rate filings this week indicating their intent to continue participating in 2018.

Unlike most of the Affordable Care Act (ACA) Marketplaces, all insurers in NMHIX will offer coverage statewide, meaning that competition will not decrease in rural areas. This is due to NMHIX's requirement that if insurers offer plans at a specific metal level (i.e. bronze, silver, gold, or platinum), at least one of those plans must be offered statewide. As a result, New Mexico is one of only eight states projected to have more than three Marketplace insurers in every county for 2018.

New Mexico is also one of a handful of states allowing insurers to submit two different states of proposed rates for next year (see Update for Weeks of May 29th and June 5th). The first set assumes no major changes to the ACA, while the second accounts for the elimination of the ACA cost-sharing reductions and individual mandate.

Proposed rates will not be released until later this month. However, the Trump Administration issued a press release this week claiming that one of the four NMHIX insurers, New Mexico Health Connections, is seeking an average rate increase of "nearly 80 percent", insisting that such a dramatic increase was illustrative of the failure of the ACA.

New Mexico Health Connections is one of only five remaining Consumer Owned and Operated Plans (CO-OPs) that were created with ACA loans. Most became insolvent following the \$2.5 billion shortfall in ACA reinsurance payments, as they were unable to pay the medical claims for the unanticipated numbers of enrollees that were attracted to their low premiums (see Update for Week of November 30, 2015).

The Superintendent of Insurance stressed that Marketplace premiums in New Mexico have been among the lowest the nation, running about 30 percent below the \$476 per month average in 2017 for states that use the federal Marketplace web portal.

Tennessee

Three insurers currently plan to serve ACA Marketplace for 2018

BlueCross BlueShield (BCBS) of Tennessee and CIGNA submitted preliminary rate filings this week demonstrating their intent to participate in the Affordable Care Act (ACA) Marketplace for 2018.

BCBS will re-enter the Knoxville region, which was left without any Marketplace options when Humana decided not to return for 2018. It will serve most of the rest of the state except for the Memphis and Nashville metro areas, both of which will be covered by CIGNA. A recent start-up, Oscar Health, also announced plans to enter the Nashville area alongside CIGNA (see above).

BCBS warned that its decision is conditioned upon the Trump Administration fully-funding the cost-sharing reductions under the ACA (see Update for Weeks of May 29th and June 5th) and that the elimination of those subsidies or other "changes at the federal level" could "impact our decision on whether to sign the agreement in September."

Washington

More than half of 2018 rate hikes are due to uncertainty over ACA subsidies, individual mandate

The Office of the Insurance Commissioner (OIC) announced this week that Affordable Care Act (ACA) Marketplace insurers are seeking an average premium increase of 22.3 percent for 2018.



Commissioner Mike Kreidler (D) stressed that more than half of the proposed hikes are attributed to the uncertainty over whether the Trump Administration will fully-fund the ACA cost-sharing subsidies through the 2018 plan year and enforce the law's individual mandate. Without that uncertainty, insurers would have been seeking only a 10.6 percent average hike for 2018.

A survey released last week by Oliver Wyman health consultants predicted that up to two-thirds of rate hikes in the 2018 Marketplaces would be attributable to the uncertainty related to those two key provisions.

The Commissioner also announced that he persuaded at least one insurer (Premera Blue Cross) to offer two Marketplace options in 2018 for consumers in Grays Harbor County. The move leaves only one county (Klickitat) unserved for next year (see Update for Weeks of May 29th and June 5th).