



Health Reform Update – Week of October 2, 2017

CONGRESS

Senate Republicans vow to continue fight to repeal ACA despite latest setback

Senate Majority Leader Mitch McConnell (R) withdrew plans to vote last week on a measure that would repeal key provisions of the Affordable Care Act (ACA) and replace them with block grants to states from 2020-2026.

The legislation introduced last month by Senators Bill Cassidy (R) and Lindsey Graham (R) was the latest iteration of H.R. 1628, the House-passed bill that sought to eliminate the ACA's individual and employer mandates, Medicaid expansion, premium and cost-sharing subsidies, and most taxes while converting Medicaid into a block grant program with per capita spending caps (see Update for Week of May 8th).

Prior versions failed to garner the support of the 50 Senators needed to fast-track legislation through budget reconciliation with only a simple majority (Vice President Pence would break the tie). Moderate Senators from states that had expanded Medicaid largely objected to the loss of billions of dollars in expansion funding, while others disapproved of the dramatic increase in out-of-pocket costs or the rush to pass the legislation without hearings or Congressional Budget Office (CBO) cost estimates see Update for Week of August 14th).

The same objections scuttled the Cassidy-Graham bill with Senators Susan Collins (R-ME), Lisa Murkowski (R-AK), and John McCain (R-AZ) still providing the three negatives to block its Senate passage. However, they were joined this time by conservative Senators Rand Paul (R-KY) and Ted Cruz (R-TX), two of the Senate's staunchest opponents of the ACA who insisted that the bill did not go far enough in repealing the ACA.

The Senate Majority Leader had sought to push the Cassidy-Graham bill through the Senate prior to the September 30th end of the federal fiscal year, when their reconciliation authority granted by a fiscal year 2017 budget resolution expired. The Senate Finance Committee did hold a hearing on the bill, which had not occurred with prior versions (see Update for Week of July 10th). However, the Majority Leader withdrew the bill late that day when it became apparent that it would fail on the Senate floor.

Despite the defeat, Senator Cassidy pledged to make changes to the legislation that would be needed to secure support from reluctant Senators and move it forward next year following a full CBO score. The initial fiscal year 2018 budget resolution drafted by Senate leaders does include new reconciliation instructions that would allow for at least a limited repeal of certain ACA provisions (such as the individual and employer mandates) with only 50 votes.

Ways and Means committee advances bill to repeal Medicare cost-cutting board

The House Ways and Means Committee approved legislation this week that would repeal the Independent Payment Advisory Board (IPAB) that the Affordable Care Act (ACA) created to control Medicare cost growth.

The panel, which has never gone into effect, was designed to make recommendations on Medicare spending cuts whenever costs exceeded pre-determined targets. These recommendations would automatically go into effect if Congress failed to pass equivalent cuts.



The IPAB was controversial from the start with Republicans insisting it was “Soviet-style central planning” and a form of a “death panel” (see Update for Week of March 19, 2012). However, significant numbers of Democrats also opposed the panel, fearing it would cede authority away from Congress and into the hands of “unelected bureaucrats” (see Update for Week of December 1, 2014). As a result, both the Obama or Trump administrations have chosen not to nominate members to serve on the panel, meaning that the Secretary for the Department of Health and Human Services would make the required recommendations if spending cuts were triggered.

Legal challenges to the IPAB brought by the conservative Goldwater Institute and House Republicans have also been rejected by the U.S. Supreme Court as “premature” since the panel does not yet exist (see Update for Week of March 30, 2015). The plaintiffs have pledged to renew the lawsuit if the 15 panel members are appointed.

The House repeatedly passed individual measures to repeal the IPAB (see Update for Week of June 22, 2015) and its elimination was consistently part of larger bills to repeal and replace the ACA (see above). The current legislation sponsored by Rep. Phil Roe (R-TN)(H.R. 849) is cosponsored by 43 Democrats and easily cleared committee by a 24-13 vote. Senators John Cornyn (R-TX) and Ron Wyden (D-OR) have each introduced similar repeal measures in the Senate.

Although Democrats support repealing the panel in committee, many have refused to do so on the House or Senate floor because Republican and Democratic leaders have been unable to agree on how to offset the \$17.5 billion over ten years that an IPAB repeal would cost, according to the Congressional Budget Office. H.R. 849 likewise does not include offsets and will likely be unable to pass the Senate without them, even if it clears the House.

However, even if the IPAB remains in place, Ways and Means committee staff acknowledge that its recommendations are unlikely to be triggered until at least 2022 due to the unprecedented slowdown in overall health care cost growth, according to Medicare trustees and the CBO.

Senate HELP Committee resumes bipartisan negotiations on Marketplace stabilization plan

Senator Lamar Alexander (R-TN) agreed this week to resume negotiations with Democratic leaders on a bipartisan compromise that would stabilize Affordable Care Act (ACA) Marketplaces in the short-term and mitigate premium spikes that are resulting from uncertainty over the ACA’s fate.

The Senate has held four hearings on a Marketplace stabilization plan since returning last month and made progress on a compromise bill that would give states greater flexibility to pursue federal waivers allowing them to opt-out of key ACA provisions in exchange for assurance that the ACA’s cost-sharing reductions (CSRs) would continue to be funded. However, bipartisan negotiations were abruptly ended when Senate leaders decide to renew their push to repeal key provisions of the ACA (see Update for Week of September 18th).

Once negotiations resumed following the withdrawal of the ACA repeal bill (see above), Senator Alexander, who chairs the Health, Education, Labor, and Pensions (HELP) Committee, has been willing to include funding for the ACA’s cost-sharing reductions (CSRs) as part of the bill, but only for two years. According to America’s Health Insurance Plans (AHIP), the potential loss of CSRs during the plan year has been the primary reason that insurers have sought to increase premiums by 20 percent or more, or leave the Marketplaces altogether (see Update for Week of August 28th).

However, the sticking point in negotiations remains exactly how much flexibility states will be allowed to pursue alternatives to the ACA. Since January 1st, Section 1332 of the ACA has let states seek State Innovation Waivers allowing them to experiment with alternate reforms that provide comparable coverage to the ACA without increasing the deficit. Republicans want to eliminate or greatly relax these safeguards, which Democrats are not willing to do without protections to ensure consumer



out-of-pocket costs do not dramatically rise, especially if states are allowed to opt-out of ACA rules mandating coverage of essential health benefits and prohibiting insurers from increasing premiums based on health status.

Senators Alexander and John Thune (R-SD) acknowledged this week that even though party leaders are “close” to a deal in the Senate, it may be more difficult to find common ground in the House where its most conservative members (comprising the House Freedom Caucus) largely oppose any efforts to “fix” and not repeal the ACA. House Democrats have urged Energy and Commerce Committee chairman Greg Walden (R-OR) to immediately start similar negotiations, to no avail.

Congress misses CHIP reauthorization deadline

The aborted effort to repeal and replace the Affordable Care Act (ACA) last week caused Congress to miss the deadline for reauthorization the Children’s Health Insurance Program (CHIP for the coming fiscal year.

Two belated reauthorization bills are making their way through the House and Senate. The latter (S. 1827) cleared the Senate Finance Committee without objections, since it has yet to include language on how to offset the new costs. It would renew CHIP funding for up to five years but with a reduction from the current 23 percent funding spike provided by the ACA (down to 11.5 percent before reverting back to traditional levels). However, the House version (H.R. 3291) was largely opposed in committee by Democrats who objected to the offsets sought by Republicans, including reducing CHIP’s 90-day grace period for premium payment, adding a new levy on high-income Medicare enrollees, and cutting \$6.35 billion from the ACA’s Prevention and Public Health Fund. In addition, Democrats insist that the \$1 billion in funding for Puerto Rico’s Medicaid program (over two years) is insufficient in light of the state’s financial crisis and devastation from two hurricanes.

Several states are already invoking back-up plans in case new CHIP funding is not imminently approved, as most would run out of funding by the end of the year. Minnesota and Utah are preparing to move children covered through CHIP into their Medicaid programs. Colorado would shift CHIP children into their state-based Marketplace created under the ACA if Congress does not provide funding by mid-December.

Senate Democrats call for OIG investigation into HealthCare.gov shutdowns

A group of Senate Democrats have formally asked the Department of Health and Human Services (HHS) Office of Inspector General (OIG) to investigate the Trump Administration’s decision to shut down the federal HealthCare.gov web portal from midnight to noon almost every Sunday through the 2018 open enrollment period.

Senators Brian Schatz (D-HI), Elizabeth Warren (D-MA), Cory Booker (D-NJ), and Chris Murphy (D-CT) insist that they have received “no satisfactory explanation...for why these shutdowns are necessary” and insist that they “appear to be part of a pattern by the Trump administration to sabotage the Affordable Care Act.” They note that the Administration has previously cut the open enrollment period in half (from 90 to 45 days) and slashed federal funding for Marketplace advertising and outreach by 90 percent (see Update for Week of September 18th). Just last week, HHS announced it would no longer send representatives to participate in Marketplace enrollment events during the sign-up period, a departure from agency practice in prior years.

Former acting Centers for Medicare and Medicaid Administrator Andy Slavitt used the decision to withdraw from enrollment events as further evidence to support allegations by former Obama Administration officials and Congressional Democrats that the Trump Administration was “deliberately sabotaging” the Marketplaces in an effort to depress enrollment. They point to the Administration’s



decision to cut previously-bought advertising at the end of the 2017 open enrollment period (see Update for Week of January 30th), as well as threats to eliminate the cost-sharing reductions (CSRs) under the Affordable Care Act (see Update for Week of August 14th), which insurers claim are causing them to increase 2018 premiums by 20 percent or more (see below).

The Senators were joined by a group of 78 House Democrats in urging HHS to shorten the web portal shutdowns and lengthen the open enrollment period.

Renewed House bill would require Marketplace insurers accept charitable assistance

Rep. Kevin Cramer (R-ND) reintroduced legislation this week that would prevent insurers in Affordable Care Act (ACA) Marketplaces from refusing to accept third-party premium and copayment assistance from non-profit, charitable organizations like PSI.

Since 2014, the Centers for Medicare and Medicaid Services (CMS) has given Marketplace insurers the discretion to refuse third-party assistance from non-profit 501(c)(3) groups, which includes charitable organizations including churches (see Update for Week of June 2, 2014). Since that interim final rule went into effect, more than 70 plans in 41 states have exercised this discretion.

PSI strongly backed the previous version of this bill (H.R. 3742), which had broad bipartisan support with 146 cosponsors before the end of last session (92 Republicans and 54 Democrats) (see Update for Week of January 30th). A “Dear Colleague” letter sent to CMS earlier this year by Reps. Cramer and Doris Matsui (D) received even more support, with Democrats making up 95 of the 181 members who signed on (see Update for Week of May 29th and June 5th).

The new bill (H.R. 3976) is largely the same as the prior version, but was amended to clarify that it applies to copayment as well as premium assistance. In addition, both forms of assistance would count towards a subscriber’s annual out-of-pocket limit.

PSI is pushing for the bill to receive a public hearing in the Energy and Commerce Committee, in which CMS would have to explain the basis for its decision to require Marketplace insurers accept third-party assistance from federal and state health care programs, but not charitable groups. CMS has continued to ignore multiple requests from Congress to provide data justifying insurer concerns that allowing charitable assistance would “skew the risk pools” towards sicker and more costly subscribers (see Update for Week of August 15, 2016).

More than 20 consumer groups that are part of the Marketplace Access Coalition founded by PSI have argued that CMS’ policy allows Marketplace insurers to effectively skirt the ACA ban on pre-existing condition denials by making plans as unaffordable as possible for those with costly illnesses. CMS previously agreed that similar practices (such as moving all drugs for a costly illness into the highest cost-sharing tier) did constitute unlawful discrimination (see Update for Week of February 23, 2015). Under the Obama Administration, it directed federally-facilitated Marketplace (FFM) states to use the plan certification process to “consider” whether the practice of refusing third-party assistance was likewise discriminatory (see Update for Week of September 12, 2016).

However, CMS reversed that decision earlier this year when it decided to stop making these determinations as part of the plan certification process for FFM states (see Update for Weeks of May 15th and 22nd). That CMS guidance cited the executive order that President Trump issued upon entering office, which directed agencies to find ways to provide “greater flexibility” to states in administering the ACA (see Update for Week of January 30th).

FEDERAL AGENCIES



Regulators criticize proposed executive order allowing interstate sales of health plans

President Donald Trump announced last week that he will shortly issue a “very major executive order” allowing Americans to purchase health care across state lines.

The concept has long been championed by the recently departed Secretary of Health and Human Services (HHS) Tom Price, as well as the President himself on the campaign trail last fall (see Update for Week of December 5th). Though the specifics have yet to be announced, the order is expected to allow insurers to comply only with the regulations in the state they choose to make their primary place of business, a move that proponents insist would boost competition and lower premiums.

However, state insurance commissioners from both parties promptly criticized such a proposal noting that it was similar to a 2011 law passed in Georgia that attracted zero insurers, as well as other failed efforts in Maine and Wyoming (see Update for Week of April 9, 2012). The chief executive officer for the National Association of Insurance Commissioners emphasized this week that they have “long been opposed” to interstate health plan proposals, insisting that they would “reduce or preempt state authority or weaken consumer protections”, an argument echoed by the Republican-appointed Insurance Commissioner in Maryland. Washington Insurance Commissioner Mike Kreidler (D) stated that insurers in his state “absolutely cringe when you talk about across-state sales” and argued that state law would “supersede an executive order”.

The head of Blue Shield of California has been on record as opposing interstate health plan proposals, insisting they would create a “race to the bottom” (see Update for Week of January 30th).

STATES

Arizona

Blue Cross Blue Shield backs off rate hike, will cut Marketplace premiums for 2018

Blue Cross Blue Shield (BCBS) of Arizona announced this week that it will decrease premiums next year by an average of one percent for all of its individual health plans, instead of the 7.2 percent average increase that it had initially proposed.

The move will most dramatically impact roughly 45,000 consumers in the 13 largely rural counties where BCBS will be the lone participating Marketplace insurer for 2018. The only other Marketplace insurer, HealthNet (owned by Centene Corporation), will offer coverage to about 95,000 consumers in Arizona’s two most populous counties (Maricopa and Pima) where BCBS has decided not to participate. HealthNet is seeking only a five percent average premium increase.

Unlike insurers in most states (see below), both BCBS and HealthNet are assuming the Trump Administration will continue to fund the cost-sharing reductions under the ACA for the plan year. BCBS was willing to reduce premiums after a dramatic increase in first quarter profits (\$56 million compared to only \$5 million during the same point in 2016)(see Update for Weeks of May 29th and June 5th).

The nominal increases are a stark contrast to last fall, when BCBS hiked rates by a 51 percent average and HealthNet was allowed an even greater increase of nearly 75 percent (see Update for Week of October 24, 2016). Some counties saw premiums increase by up to 115 percent for 2017, which President Trump frequently cited during the campaign as evidence that “Obamacare was failing.”

Prior to 2017, Arizona had one of the most robust Marketplaces in the nation with up to 11 participating insurers and among the lowest average premiums at only \$324 per month in 2016 (far below the \$396 average for other federally-facilitated Marketplaces). However, many insurers greatly underpriced their plans due to the significant competition, forcing them to either make dramatic



corrections once the ACA reinsurance payments for exceptional claims expired in 2016 or leave the Marketplace altogether, as large insurers like UnitedHealthcare and CIGNA chose to do (see Update for Week of September 12, 2016).

According to the Department of Insurance, 2018 premiums for a 40-year-old single Maricopa County (Phoenix area) resident who does not use tobacco will rise to \$475 per month for silver-tier coverage. A 40-year-old couple with two children would pay \$1,422 per month for a comparable family plan.

California

Marketplace will boost silver plan rates if ACA subsidies not guaranteed by next week

Covered California officials confirmed this week that they will impose a surcharge on silver-tier plans if the Trump Administration does not provide assurances by October 11th that the cost-sharing reductions (CSRs) provided by the Affordable Care Act (ACA) will remain in place for the full plan year.

The 12.4 percent surcharge would be imposed on top of the 9.2 percent average premium increase for silver-tier plans in 2018. Consumers in bronze-tier plans will see an average increase of 11.8 percent, regardless of whether the CSRs are eliminated.

Covered California consumers will face an average rate hike of 12.5 percent in 2018 across all plans. According to the executive director, that already included roughly a three percent increase due to uncertainty over the fate of the CSRs. The 12.5 percent overall increase was only slightly lower than the 13.2 percent average rate hike for Covered California consumers in 2017, a spike that followed years of only single-digit average increases.

Covered California remains a robust Marketplace with all 11 participating insurers returning next year. However, Anthem Blue Cross will retreat from all but three of the state's 19 rating areas, meaning that roughly 60 percent of its Marketplace consumers will have to move to other plans for 2018.

Florida

ACA uncertainty causes average Marketplace rate hike to jump from 18 to 45 percent

Final approved rates released last week by the Office of Insurance Regulation (OIR) reveals that Marketplace consumers will face an average premium increase of 44.7 percent in 2018, thanks in large part to the uncertainty over whether the Trump Administration will continue the cost-sharing reductions (CSRs) under the Affordable Care Act (ACA).

The six participating Marketplace insurers had sought an average rate hike of 17.8 percent last June. However, Florida was one of several states that allowed insurers to submit a back-up set of rate filings that assumed the CSRs would not be fully funded during the entire plan year. OIR ultimately decided to go with the back-up rates following continued Congressional efforts to repeal key provisions of the ACA, including the CSRs (see Update for Week of September 18th).

Regulators stressed that 31 percentage points of the 44.7 percent increase is "directly attributable" increase in silver-tier premiums, which are the only plans for which CSRs are available. Other tier plans will still see the roughly 18 percent average increase that insurers initially sought.

However, regulators also emphasized that 93 percent of Marketplace consumers in Florida are likewise eligible for premium tax credits under the ACA (compared to 84 percent nationwide), thereby mitigating much of average increase. Furthermore, consumers enrolled in silver-tier Marketplace plans that are ineligible for ACA tax credits will be allowed to purchase silver-tier coverage outside of the Marketplace that does not have the "extra cost" of the added premium to compensate for the loss of CSRs.



Three-quarters of Marketplace consumers in Florida received CSRs in 2017 (compared to just 57 percent nationwide). CSRs are only available to those earning 100-250 percent of the federal poverty level.

Florida enrolled more than 1.76 million consumers in their federally-facilitated Marketplace during the 2017 open enrollment period, by far the most in the nation. (California's state-based Marketplace was second with just over 1.5 million.) It was among the few Marketplaces that actually increased enrollment in 2017, increasing by one percent despite the nationwide decline of five percent (see Update for Week of January 30th).

Part of the reason for the success of Florida's Marketplace is that individual market enrollment is double the national average (12.7 percent compared to 6.4 percent), and in south Florida counties that number approaches 20 percent. Healthy competition in the Marketplace has restrained premium increases in past years, as Florida's 14 percent increase for 2017 was well below the national average of 22 percent.

Humana was the only carrier to exit the Florida Marketplace for 2018. However, despite the healthy number of remaining participants, participating is heavily localized. Florida Blue will be the only carrier offering coverage in 42 of the state's 67 counties, leaving most of the northern part of the state with only one coverage option.

Florida Blue officials insist that they remain committed to the Marketplace but warned as early as last spring that they would increase premiums by at least 20 percent to offset any potential loss of CSRs (see Update for Week of May 8th). They received an average increase of 38.1 percent, well above the 9.3 to 24.7 percent increases they had initially sought, while premiums for their Health Options HMO will increase by a 36 percent average (more than triple their initial rate filing).

However, the highest premium increase was awarded to Molina Health Plan, which received a staggering 71.2 percent average rate hike, compared to the 37.5 percent increase they sought prior to assuming CSRs would be eliminated. Ambetter/Celtic plans will receive a 46.1 percent increase, which is nearly four times the increase they initially proposed.

The nearly 45 percent average increase for Florida's Marketplace is second only to Georgia, where Marketplace consumers will face a 57 percent average hike. Both states defaulted to the federally-facilitated Marketplace and refused to participate in the Medicaid expansion under the ACA.

Idaho

Regulators blame 70 percent of average rate hikes on uncertainty over cost-sharing subsidies

Individual market premiums finalized last week by the Department of Insurance show that premiums will increase by 27 percent on average for 2018, due to their assumption that the Trump Administration will eliminate the cost-sharing reductions (CSRs) under the Affordable Care Act (ACA) at some point during the plan year.

The six individual market insurers had sought a 38 percent average increase, which the Department found excessive. However, regulators still allowed a dramatic 40 percent increase on premiums for silver-tier plans, the only plans for which the CSRs are available within the ACA Marketplace. By contrast, premiums for bronze and gold tier plans will increase by only 8-9 percent on average (platinum plans are not offered).

Regulators attributed 70 percent of the entire average rate hike to the uncertainty over CSRs and acknowledged that average premiums would only be increasing by 8.1 percent if the Trump Administration had guaranteed the availability of the CSRs for the full plan year.



Maine

Anthem abruptly exits ACA Marketplace for 2018

Anthem Blue Cross Blue Shield announced last week that it would no longer participate in the Affordable Care Act (ACA) Marketplace starting in 2018.

The abrupt announcement came only one day before the deadline for insurers in federally-facilitated Marketplaces to decide whether to participate. Anthem had submitted rate filings for 2018 and received an 18 percent average premium increase from the Bureau of Insurance (see Update for Week of September 18th). However, it indicated at the time that it would leave the Marketplace mid-year should the Trump Administration stop funding the ACA cost-sharing reductions (CSRs).

The Bureau of Insurance has asked all three Marketplace insurers to submit two sets of proposed rates for 2018, one that assumed the CSRs would be fully-funded and another “back-up plan” that accounted for their elimination. While Community Health Options and Harvard Pilgrim provided a “back-up plan” that raised premiums, Anthem’s “back-up” plan was simply to exit the Marketplace.

The decision by Congressional Republicans to scuttle a short-term Marketplace stabilization plan in a favor of a third failed attempt to repeal key provisions (see above) prompted Anthem officials to invoke their “back-up” plan immediately instead of waiting for the 2018 open enrollment period to start.

Anthem had already decided to leave most of its Marketplace business for 2018 but did reverse course and agree to remain in states like Missouri and Virginia, where its departure would have left several counties with no participating insurers (see Update for Week of September 18th). That is not the case in Maine, where consumers in every county will still have at least one Marketplace insurer.

Anthem will allow current plans to renew coverage for January 1st, but only for outside of the Marketplace where no ACA subsidies are available. For new enrollees, only one gold tier plan will be available off the Marketplace for Aroostook, Hancock and Washington counties. Anthem has roughly 28,000 individual market enrollees, but expects that number to fall dramatically to only 5,600 for 2018.

Maryland

Federal court allows unprecedented prescription drug price-gouging law to go into effect

The chief judge for the U.S. District Court for the District of Maryland rejected an effort last week by generic drug manufacturers to prevent the nation’s first law prohibiting prescription drug price-gouging.

Governor Larry Hogan (R) allowed H.B. 631 to become law without his signature last spring, despite insisting it was “unconstitutional” and was not “a solution to ensuring that Marylanders have access to essential prescription drugs” (see Update for Weeks of May 29th and June 5th). It specifically seeks to prevent increases of 50 percent or more (within one year) in the wholesale acquisition cost for “essential” generic or off-patent drugs.

The Association for Accessible Medicines (formerly the Generic Pharmaceutical Association) promptly filed suit seeking to block the law’s implementation on the basis that it was unconstitutionally vague and goes against U.S Supreme Court and appellate court precedent that “clearly restrict[s] states from directly regulating wholly out-of-state commercial activity.” It sought a preliminary injunction on the basis that implementation of the law would restrict competition and limit patient access without reducing the price of essential drugs, as the “untenable uncertainty [created] for generic drug makers [would give them] no choice but to abandon markets altogether.”

Judge Garbis (appointed by President G.W. Bush) will allow the Association’s claim of vagueness to go forward but dismissed the remaining claims. However, he was not willing to stop the law from going



into effect, insisting that he was not convinced the Association would prevail and that an “erroneous grant of a preliminary injunction would cause substantial harm by permitting the sale of essential drugs to Maryland residents at unconscionable prices.”

The Association has pledged to appeal the denial of the injunction to the U.S. Fourth Circuit Court of Appeals.

Minnesota

Reinsurance program credited with holding premiums steady despite assumed loss of CSRs

The Department of Commerce announced this week that final approved premiums for MNSure will hold steady for 2018 or in many cases decline.

Average premium increases within the Marketplace created pursuant to the Affordable Care Act (ACA) will range from a 13 percent decrease to an increase of less than three percent, a dramatic departure from 2017 when consumers experience a 59 percent jump in average premiums. Both Republican and Democratic lawmakers responded to that spike in premiums by providing temporary premium rebates for 2017 and making Minnesota the second state behind Alaska to create a reinsurance program to compensate insurers for exceptional claims (see Update for Week of May 8th).

Commerce officials credit the reinsurance program with restraining rate hikes for 2018, emphasizing that it was the expiration of the ACA’s reinsurance payments at the end of 2016 that led to the dramatic premium increases for this year (see Update for Week of January 9th). Minnesota is currently using \$271 million in state funds to operate the program but seeking a federal waiver similar to Alaska’s that would allow it to continue for five years with mostly federal dollars. However, that waiver is currently in limbo as the Trump Administration has sought to offset the cost by eliminating federal funding for Minnesota’s Basic Health Plan option under the ACA (see Update for Week of September 18th).

As with most other states, final premiums in Minnesota assumed that the Trump Administration would not fully fund the ACA’s cost-sharing reductions (CSRs) during the entire plan year. However, unlike most other states, the potential loss of these subsidies did not result in premium spikes because insurers would still be compensated for extraordinary claims. Commerce officials did stress that rates would have been much lower in Minnesota had CSR funding been guaranteed, noting that HealthPartners would have slashed premiums by nearly a 15 percent average instead of the 7.5. percent average decline that subscribers will now see.

The largest MNSure participant, Blue Cross and Blue Shield of Minnesota, will increase rates by only an average of 2.8 percent while premiums will fall by an average of 0.4 percent for Medica and 13.3 percent for UCare. According to Commerce officials, the “benchmark” premium (i.e. second-lowest cost silver plan) for a 40-year-old buying coverage in Hennepin County will fall by 11 percent to \$327 per month next year. The same consumer in St. Louis County will face “benchmark” premiums of about \$426 (or four percent less than 2017). However, the same consumer in Olmsted County will pay \$596 per month (an increase of seven percent).

New Hampshire

Marketplace premiums to spike by 52 percent for consumers not eligible for ACA subsidies

Officials with Gorman Actuarial Inc. told the Commission to Evaluate the Effectiveness and Future of the Premium Assistance Program this week that premiums for consumers who purchase coverage in the Affordable Care Act (ACA) Marketplace will increase next year by an average of 52 percent if they are not eligible for ACA premium tax credits.



The consultant predicted by roughly 25,000 individuals would face this premium spike, causing just over half to likely forgo coverage for 2018. Another 28,000 consumers who are eligible for the tax credits would be able to continue to purchase Marketplace coverage with little or no change in out-of-pocket costs, while another 43,000 whose Marketplace premiums are paid through the Premium Assistance Program (PaP) will not be affected.

New Hampshire is one of eight states that received federal approval to use ACA matching funds for the Medicaid expansion to instead purchase private coverage for those that the law makes newly-eligible for Medicaid (see Update for Week of September 29, 2014). The PaP has been very successful, enrolling more than 52,000 consumers or roughly 42 percent of the entire individual market (see Update for Week of August 14th). However, Republican lawmakers have reauthorized the program only through the end of 2018 and created the Commission to recommend more conservative-favored reforms such as work requirements and eligibility verification measures that were disallowed by the Obama Administration (see Update for Week of December 5th).

Governor Chris Sununu (R) used Gorman's projections of premium spikes as further evidence that "Obamacare has failed and must be replaced," along with the Medicaid expansion. However, he has continue to support modifying instead of eliminating the PaP, including changes to the provider assessment used to fund the program, which the Trump Administration determined was unlawfully being conditioned on the receipt of voluntary donations from hospitals (see Update for Week of August 14th).

Among the changes being discussed by the Commission include moving PaP enrollees into their own high-risk pool, which Gorman claims would lower medical costs for other Marketplace subscribers by at least 14 percent. Commission Chairman and Senate Majority Leader Jeb Bradley (R) has also suggested moving-out those the state identified as medically frail whose costs tend to be more than three times higher than other enrollees (according to Gorman). However, Anthem Blue Cross and Blue Shield of New Hampshire has cautioned that this could impact more than a third of PaP enrollees.

Congresswoman Carol Shea-Porter (D-NH) stated that she was "outraged" by the failure of the Gorman report to point out that the 52 percent premium spike resulted from the uncertainty created by Trump Administration's refusal to guarantee the ACA cost-sharing reductions will be available to insurers for the entire plan year. She stressed that most other states are experiencing average premium hikes of 20 percent or more due to this uncertainty (see above).

Oklahoma

Health commissioner blames lack of federal waiver for higher premiums

Commissioner of Health Terry Cline formally withdrew Oklahoma's request this week for a federal waiver that sought to use \$350 million in Affordable Care Act (ACA) funding to create a reinsurance program that would mitigate premium increases in the individual market for 2018.

Since January 1st, Section 1332 of the ACA has allowed states to seek State Innovation Waivers allowing them to opt-out of key ACA provisions and experiment with reforms that provide comparable coverage and are deficit-neutral. The Trump Administration approved Alaska's request for a State Innovation waiver to operate a reinsurance program, which dramatically reduced premium hikes by compensating insurers for extraordinary claims, and encouraged other states to follow suit (see Update for Week of July 10th).

However, the Administration has been reluctant to approve additional waivers, telling Minnesota last month that the cost must be offset by the elimination of other ACA funds (see Update for Week of September 18th) and failing to act on Oklahoma's request by their stated September 22nd deadline.

The federal Centers for Medicare and Medicaid Services (CMS) did not state any reason for the delay and insisted they actually had until February 2018 to make a decision. However, Commissioner



Cline stressed that the waiver had to be approved by the end of September so before final premiums were set for the state's lone participating Marketplace insurer (Blue Cross and Blue Shield).

As a result of the waiver withdrawal, the Commissioner insists that Marketplace consumers will face premiums that are 34 percent higher on average.

Washington

ACA uncertainty leads to unprecedented hike in Marketplace premiums

The Washington Health Benefit Exchange board approved final premiums this week for 2018 that will allow the largest average increases since the state created the Affordable Care Act (ACA) Marketplace in 2013.

The average increase of 24 percent are more than double the 11 percent hike approved for 2017, and the four percent and one percent hikes approved for 2016 and 2015 (see Update for Week of October 24, 2016).

The chief executive officer for the Exchange cited the uncertainty over whether the Trump Administration will continue the cost-sharing reductions (CSRs) under the ACA as the primary factor in the substantial increase, as well as questions about whether the ACA's individual mandate will be enforced. Insurance Commissioner Mike Kreidler (D) acknowledged that "it's very hard for a regulator to deny those rate increases" because the "uncertainty made it difficult to determine how much of an increase would be justified."

In addition to the rate hikes, Exchange consumers will also have fewer insurance options from which to choose. The two most populous counties (King and Pierce) will have only four participating insurers, down from seven this year. Consumers will Snohomish County will lose half their insurers (from six to three) and Kitsap County will drop from four to three.

Commissioner Kreidler successfully persuaded three insurers to enter the two rural counties (Grays Harbor and Klickitat) that were threatened to be left with zero insurers for next year, meaning that every county in the state will have at least one participating insurer (see Update for Week of July 10th).