

Health Reform Update – Week of January 22, 2018

CONGRESS

Temporary spending bill reauthorizes CHIP, delays key ACA taxes

President Trump signed a stopgap spending bill this week that ended a brief government shutdown and will keep the government funded through February 8th.

Congress had already passed two stopgap bills to keep the government open past the September 30th end of the federal fiscal year. Democrats were able to use the shutdown as leverage to include a six-year reauthorization of the Children's Health Insurance Program (CHIP) into the latest measure (H.R. 195). However, Republicans successfully included a delay of several Affordable Care Act (ACA) taxes.

Republican leaders had allowed CHIP funding to expire on September 30th while they debated measures that would repeal key ACA provisions (see Update for Week of November 6th). A previous temporary spending resolution did provide states with \$2.85 billion in emergency funds that was intended to last through March 31st. However, the Georgetown University Center for Children and Families found that CHIP funding was still set to run out by the end of January in 24 states, threatening to leave nearly two million of the nine million CHIP enrollees without coverage.

Subsequent attempts to reauthorize CHIP for five years failed after Senate Democrats refused to go along with Republican plans to offset the \$8.2 billion cost by further cutting the ACA's Public Health and Prevention fund (see Update for Week of November 13th). However, that impasse was broken earlier this month when the Congressional Budget Office (CBO) concluded that Congress' elimination of individual mandate penalties under the ACA (see Update for Week of December 18th) meant that the federal government would actually save money by funding CHIP for at least six years. This is because CHIP enrollees would otherwise be forced into ACA Marketplace plans where the federal government would have to pay premium subsidies whose cost would exceed CHIP coverage (see Update for Week of January 8th).

Although the CHIP reauthorization under H.R. 195 will be budget neutral, the Joint Committee on Taxation determined this week that delay of three key ACA taxes would actually increase the federal deficit by \$31 billion. Nearly half of this amount is due to postponing implementation of the 40 percent excise tax on high-cost or "Cadillac" health plans until 2022 (it had previously been delayed from 2018 to 2020). H.R. 195 will also put a one-year moratorium on the annual tax on health insurers as well as a two-year delay in the 2.3 percent annual tax on medical device manufacturer revenues. Both taxes went into effect on January 1st and were projected to fund the premium tax credits under the ACA (that remain in effect).

Negotiations for a full-year spending bill continue to be complicated by two issues. The first is whether to include any of the bipartisan bills to stabilize ACA Marketplaces (see Update for Week of November 13th). Senate Majority Leader Mitch McConnell (R) had pledged to hold votes on these bills in exchange for key support from moderate Republicans for repealing the ACA's individual mandate as part of the Republican tax bill (see Update for Week of January 8th). However, the conservative House Freedom Caucus remains opposed to any ACA "fix" legislation.

In addition, Congress is still at an impasse over what to do with children of undocumented immigrants previously protected by the Deferred Action for Childhood Arrivals (DACA) program created by President Obama. DACA protections are set to expire in March under an executive order issued by President Trump but other Democratically-controlled states are likely to follow New York's lead and allow them to remain eligible for Medicaid coverage should the program end.

Senate Democrats are likely to insist on a resolution to these two issues before providing the nine votes needed break a filibuster and pass any spending bill.

FEDERAL AGENCIES

States sue HHS over cuts to Basic Health Plan funding

The attorneys general for New York and Minnesota filed suit this week against the Department of Health and Human Services (HHS) alleging that it unlawfully cut \$1 billion in funding for the Basic Health Plan (BHP) option under the Affordable Care Act (ACA).

The two states were the only ones to exercise the BHP option, in which the federal government pays 95 percent of the costs for states to cover those earning 138-200 percent of poverty in a lower-cost plan than the Marketplace that comes with no deductibles, limited copayments, and premiums of no more than \$20 per month (see Update for Week of July 10th). The BHP payments that New York and Minnesota received from HHS thus previously equaled 95 percent of the ACA premium tax credits and cost-sharing reductions (CSRs) that BHP enrollees would have received had they remain in an ACA Marketplace plan. However, HHS notified both states on December 21st that the cost-sharing component of their BHP payments would no longer be made following President Trump's decision to terminate the ACA cost-sharing reductions paid to insurers (see Update for Week of November 6th).

The lawsuit was filed in the U.S. District Court for the Southern District of New York. Its primary argument is that because the ACA statute itself requires the BHP payment include both the premium tax credit and CSR component, HHS cannot arbitrarily and capriciously void the CSR component with Congress changing the statute. However, it also alleges that HHS violated the federal Administrative Procedures Act by ignoring the states' proposal to simply revise the payment calculation so that the premium tax credit portion they receive from HHS accounts for "silver loading", which was how most state insurance commissioners compensated for the loss of CSRs (by increasing premiums solely on silver-tier plans). BHP enrollees in both states would have faced higher silver-plan premiums had they remain in the Marketplace and thus higher premium tax credits.

The New Jersey legislature is currently considering legislation that would allow that state to also exercise the BHP option (see Update for Week of January 8th).

STATES

Idaho

Insurance commissioner details plan to allow non-complaint ACA plans, insists they are not "illegal"

Department of Insurance Director Dean Cameron (R) released details this week of his proposal to allow insurers to sell individual health plans that do not comply with Affordable Care Act (ACA) consumer protections.

The Director's proposal responds to the earlier executive order from Governor Butch Otter (R), authorizing the agency to create limited benefit plans that cost 30-50 percent less (see Update for Week of January 8th). Director Cameron insisted that the move was necessary to mitigate premium spikes by giving consumers the option to purchase only those benefits they need, instead of plans that mandate the coverage of all essential health benefits under the ACA, including mental health, maternity care, and prescription drugs.

The new limited benefit plans will be able to exclude coverage for those with pre-existing conditions for up to 12 months if the consumer had a gap in coverage of at least 63 days, thereby creating a larger pool of healthier and less costly consumers and lowering overall premiums. In addition, the plans can resume imposing lifetime benefit caps (of up to \$1 million per year), set different out-of-pocket maximums for different services (like prescription drugs), and charge consumers more based on age, health history, or place of residence.

The Director stressed that insurers would still be required to concurrently offer plans that fully-complied with the ACA, giving more costly consumers the option of purchasing more costly plans that did not exclude coverage or charge higher premiums for pre-existing conditions. However, premium tax credits offered by the ACA could only be used to purchase ACA-compliant plans.

Consumer groups like AARP Idaho immediately blasted the plan, noting that would require a federal waiver that had yet to be obtained and would only lead to “costly legal battles” as it openly defied an ACA law that remains on the books. The pointed out to internal Department of Insurance documents acknowledging that the federal Centers for Medicare and Medicaid Services (CMS) could choose to find Idaho up to \$100 per insured per day for offering non-complaint plans without federal approval. However, the Director insisted this week that the new plans were “not illegal” and would withstand the expected court challenges.

Premiums in Idaho’s individual market did spike by an average of 27 percent for the 2018 plan year, leading to the Governor’s executive order. However, Department of Insurance regulators acknowledged last fall that 70 percent of that increase was due to the Trump Administration’s elimination of cost-sharing reductions under the ACA (see Update for Week of October 2nd).

Kentucky

Governor threatens to end Medicaid expansion if courts do not uphold his work requirements

Governor Matt Bevin (R) issued an executive order this week that threatens to terminate Kentucky’s entire Medicaid expansion under the Affordable Care Act (ACA) if a federal court blocks his plan to impose higher premiums and lock-out periods on “able-bodied” adult enrollees who do not work at least 20 hours per week.

Earlier this month, Kentucky became the first state to receive federal approval to impose work requirements and lockout periods, after years of opposition by the Obama Administration (see Update for Week of January 8th). However, even the general counsel for the federal Centers for Medicare and Medicaid Services (CMS) acknowledged last month that they may be overturned by legal challenges (see Update for Week of December 18th) and the National Health Law Program, Kentucky Equal Justice Center, and the Southern Poverty Law Center, along with 15 Kentucky Medicaid enrollees, promptly filed a federal class-action lawsuit contesting the approval of the waiver.

The work requirements are projected to cut the number of enrollees in the Medicaid expansion under the Affordable Care Act (ACA) by at least 95,000. However, more than 500,000 enrollees would lose Medicaid coverage if the expansion were terminated.

Nearly a dozen other conservative-leaning states have already submitted comparable waiver requests to CMS, including Kansas and Mississippi who have proposed even more severe work requirements than those approved for Kentucky. Both are states that did not expand Medicaid under the ACA and have some of the lowest eligibility thresholds in the nation, so the work requirements would apply to people earning less than 38 percent of the federal poverty level (or \$7,759 per year for a family of three). In addition, Kansas sought to limit Medicaid coverage to only 36 months over a lifetime, regardless of whether the enrollee is working or receiving treatment for a chronic or life-threatening condition.

New Mexico

Democrats seek Medicaid buy-in waiver, individual mandate replacement, Marketplace stabilization panel

Senator Jerry Ortiz y Pino (D) and Rep. Debbie Armstrong (D) introduced measures at the outset of the legislative session that would make New Mexico the latest state consider allowing recipients of Affordable Care Act (ACA) premium tax credits to buy in to Medicaid instead of purchase private Marketplace coverage.



The plan would be modeled on the Medicaid buy-in legislation vetoed last year by Nevada Governor Brian Sandoval (R) (see Update for Weeks of June 12th and 19th) and proposed by Congressman Brian Schatz (D-HI) (see Update for Week of August 28th).

The twin resolutions (H.M.9 and S.M. 3) urge the Legislative Health and Human Services Committee to apply for a federal Section 1332 waiver in 2019 after consulting with state and federal consumer advocates, and reapply under any subsequent Administration if the waiver is rejected by the federal Centers for Medicare and Medicaid Services (CMS). Under their proposal, the buy-in option would be combined with a boost in Medicaid provider reimbursement rates.

S.M 7 by Senator Bill Talman (D) and H.M. 20 by Rep. Armstrong would also urge the Superintendent of Insurance to create a task force that would recommend ways to stabilize New Mexico's ACA Marketplace following the repeal of the ACA individual mandate in 2019, which is projected to increase premiums by at least ten percent on average (see Update for Week of December 18th). Instead of a comparable individual mandate being considered in California, Hawaii, Maryland, and several other states (see above), the resolutions propose that the Superintendent rely on auto enrollment outside of the federal waiver process.

New Mexico's ACA Marketplace is one of only a handful where all participating insurers returned for 2018 and at least three offer coverage statewide (see Update for Weeks of June 12th and 19th). However, it was beset by dramatic premium spikes following the Trump Administration's elimination of ACA cost-sharing reductions (see Update for Week of November 6th) after years of rate increases that were below the national average. For example, Molina Health plan consumers faced a 56.6 percent average increase (which rose to 69.6 percent for the most popular silver-tier plans). Christus received a 49.2 percent average premium hike while rates rose by 26.1 percent for the dominant carrier Blue Cross Blue Shield of New Mexico.

The Marketplace continues to have one of the only four remaining Consumer Operated and Oriented Plans (CO-OPs) created with ACA loans. However, the nearly \$18 million loss in 2017 for New Mexico Health Connections necessitated a 28.2 average premium increase this year.

Oregon

Voters approve tax hike to continue Medicaid expansion

More than 61 percent of Oregon voters this week approved a ballot referendum that will continue state taxes on hospitals and health insurers that fund Oregon's share of the Medicaid expansion under the Affordable Care Act (ACA).

The federal government assumed 100 percent of the costs of the Medicaid expansion through 2016. As the federal share started last year to phase down to 90 percent by 2020, the legislature increased an existing annual assessment on large hospitals (to 0.7 percent) and extended it small and rural hospitals (see Update for Week of July 10, 2017). H.B. 2391 also imposed a new 1.5 percent annual tax on health insurers as part of the reinsurance program it created to compensate insurers for extraordinary claims, which received federal approval last fall (see Update for Week of November 6th).

However, three Republican lawmakers led by Rep. Julie Parrish strenuously objected to the new taxes and started a "veto referendum" petition drive that ultimately put Measure 101 on the ballot. It gave voters the opportunity to decide whether the taxes should be eliminated, which effectively would have ended the Medicaid expansion for 350,000 Oregonians without dramatic cuts to other state services.

The assessments were backed by trade groups representing both hospitals and insurers, who helped to pour more than \$3.6 million into advertising urging "yes" votes on Measure 101. By contrast, the "no" campaign raised only \$125,000.

The taxes are expected to raise up to \$320 million to help fund the expansion, but only for two years, at which time new legislation or another ballot referendum will be needed to authorize an extension.

Measure 101 was the first ballot referendum in the nation that let voters approve a funding mechanism for the Medicaid expansion. Maine voters approved a referendum last fall that directs the state to participate in the Medicaid expansion (see Update for Week of November 6th).

Virginia

House Speaker conditions Medicaid expansion on work requirements

The Senate Education and Health Committee rejected an omnibus bill this week sponsored by Senator. Emmett Hanger (R) that would have expanded Medicaid under the Affordable Care Act (ACA) but authorized state agencies to seek a federal waiver imposing the work requirements on “able-bodied” adults.

The measure (S.B. 572) failed on a party-line 8-7 vote and was the fourth Republican rejection of a Medicaid expansion vehicle since new Governor Ralph Northam (D) was sworn into office this month, following dramatic Democratic gains last fall that left Republicans clinging to single vote majorities in both chambers (see Update for Week of January 8th). Governor Northam has been less strident than his Democratic predecessor in pushing the expansion, but insists that he remains committed to enacting some form of expansion for Virginia.

The work requirements are favored by conservative lawmakers, with the first such waiver approved earlier this month by the Trump Administration for Kentucky (see Update for Week of January 8th). Although their inclusion in S.B. 572 was not enough to draw conservative support for a straightforward Medicaid expansion, House Speaker Kirkland Cox (R) signaled that House Republicans may be open to an alternative form of Medicaid expansion that included the work requirements.

The Medicaid expansion is centerpiece of the two-year budget proposed last month by former Governor Terry McAuliffe (D), meaning that the Senate Finance Committee will likely have the final word on whether it moves forward (see Update for Week of December 18th). A full ACA expansion would bring in more than \$3.5 billion in matching funds over the two-year period. However, Senator Siobhan Dunnavant (R), an obstetrician who voted against S.B. 572, is offering an alternative to the Medicaid expansion that would forgo the ACA expansion in favor of a “global waiver” that would allow Virginia to redesign its Medicaid program.

Republican lawmakers also rejected legislation this week that would have made an insurer’s participation in Medicaid managed care conditioned upon also offering both bronze and silver-tier plans in the ACA Marketplace. Similar measures have been put in place in both Nevada and New York (see Update for Week of January 8th).

Washington

ACA Marketplace sees record enrollment despite premium spikes, federal uncertainty

The Washington Health Benefit Exchange announced this week that more than 242,000 consumers signed-up for coverage through the Affordable Care Act (ACA) Marketplace by the January 15th close of the open enrollment period.

Governor Jay Inslee (D) praised the record enrollment, which was an eight percent increase over last year despite the shorter open enrollment period and the Trump Administration’s elimination of ACA cost-sharing reductions, which had caused Marketplace premiums for those not receiving ACA premium tax credits to more than double (see Update for Week of December 18th). He stressed that because Washington was one of a dozen states (including the District of Columbia) that created their own ACA Marketplace, they were able to extend open enrollment to 12 weeks, instead of the six week period that the Trump Administration mandated for federally-facilitated Marketplaces (FFM). However, the 12-week period was still shorter than the 14-week period that Washington consumers previously had available to them.

California and New York are the only state-based Marketplaces where open enrollment continues until the same January 31st deadline as last year. Covered California officials announced this week that enrollment is outpacing last year by more than seven percent, while NY State of Health reports that they are slightly ahead, which would make it the 15th state-based or federally-facilitated Marketplace to exceed 2017 totals.

Wisconsin

Governor proposes \$200 million reinsurance program to stabilize ACA Marketplace

Governor Scott Walker (R) used his State of the State address last week to propose that the legislature create a reinsurance program that would stabilize premiums in the Affordable Care Act (ACA) Marketplace.

Alaska, Minnesota, and Oregon have already received approval from the Trump Administration to operate a reinsurance program that uses both federal and state funding to compensate insurers for exceptional claims (see Update for Week of November 6th). The program operates similar to the temporary reinsurance program created by the ACA that expired in 2016.

Under Governor Walker's plan, Wisconsin would receive \$150 million in federal reinsurance funds while the legislature would appropriate an additional \$50 million. The program would start in 2019 provide additional payments to insurers for patients with claims between \$50,000 and \$250,000. It would be paid for with projected savings from cuts in the Medicaid program, which Wisconsin has not expanded under the ACA.

Assembly Minority Leader Gordon Hintz (D) indicated that while Democrats would likely support much of the Governor's plan, he stressed that the program could be paid for entirely by expanding Medicaid, which would bring in more than \$200 million in ACA matching funds. As a carrot to Democratic lawmakers, the Governor is agreeing to seek permanent federal approval for the Wisconsin's SeniorCare program, which he twice sought to dramatically scale back despite bipartisan opposition (see Update for Week of May 23, 2011). SeniorCare uses both federal and state funds to assist more than 92,000 residents age 65 or over with their out-of-pocket prescription drug costs under Medicare Part D.

However, Governor Walker does not need any Democratic support to move his plan through the Republican-controlled legislature and indicated this week that he had already entered negotiations with the Trump Administration to secure their likely approval for the necessary federal waiver to create the reinsurance program.

Consumers in most states faced dramatic increases in the individual market for 2018, following the Trump Administration's elimination of ACA cost-sharing reduction payments to insurers (see Update for Week of November 6th). However, the increases were even higher in Wisconsin (an average of 36 percent) due the exit of Anthem Blue Cross and Blue Shield and Molina Health Care which threatened to leave Marketplace consumers in two rural counties without any insurance options until Centene agreed to step in (see Update for Week of August 14th).

Due to the premium spikes, about a dozen states are already considering similar reinsurance programs (see Update for Week of November 13th). A bipartisan Congressional bill from Senators Susan Collins (R-ME) and Bill Nelson (D-FL) would provide \$5 billion in reinsurance payments for two years. However, it has been stalled by conservative opposition (see Update for Week of December 18th).