

Health Reform Update – Week of April 16, 2018

CONGRESS

CBO predicts premiums will spike 34 percent next year due to weakening of ACA standards

A new report released last week by the Congressional Budget Office (CBO) predicts that average premiums for certain “benchmark” Affordable Care Act (ACA) plans will spike by another 34 percent for 2019, causing the federal government to shell out \$10 billion more than expected for ACA premium tax credits (a 21 percent increase).

Average premiums already increased by more than 30 percent for 2018 following the Trump Administration’s elimination of ACA cost-sharing subsidies just before the start of open enrollment (see Update for Week of November 13th). CBO largely attributes the latest spike to the Administration’s repeal of tax penalties under the ACA individual mandate (see Update for Week of December 18th) and further regulatory efforts to allow skimpier limited-benefit coverage without ACA consumer protections (see Update for Week of February 26th). Analysts predict that these initiatives (including short-term health plans and association health plans) are likely to cause the healthier and less-costly consumers most coveted by insurers into non-compliant plans while ACA Marketplace coverage becomes largely a “high-risk” pool for sicker and more costly subscribers.

Final 2018 open enrollment numbers released this week by the Trump Administration appear to bear out these concerns. Although overall enrollment unexpectedly came within 3.3 percent of 2017 totals despite dramatic cuts in the open enrollment period, advertising and marketing, and cost-sharing reductions (see Update for Week of February 26th), federally-facilitated exchanges that were not able to protect against these cuts bore almost all of the enrollment drop, with sign-ups among the age 18-35 population falling the most.

Premiums now average \$631 nationwide across all plan tiers. However, for consumers in Wyoming that figure jumped to \$983 in month while Massachusetts consumers paid the lowest average of only \$385 per month.

Senate Democrats introduce bill creating Medicare buy-in option

Senators Chris Murphy (D-CT) and Jeff Merkley (D-OR) introduced legislation this week that would let both individuals and large employers purchase Medicare coverage.

The measure would create a new Medicare benefit called Part E, which would cover traditional Medicare benefits but also provide additional coverage for maternity and pediatric care. It is similar to a bill introduced last fall by Senators Michael Bennet (D-CO) and Tim Kaine (D-VA) that would have created a Medicare Part X buy-in option but allowed only individuals (and ultimately small employers) to purchase coverage. However, the Murphy-Merkley bill would greatly expand the premium tax credits under the Affordable Care Act (ACA), increasing the upper eligibility threshold from 400 to 600 percent of the federal poverty level. Those subsidies could be used to purchase Medicare Part E coverage.

Because the bill would also base the subsidy amount on gold-tier plans (instead of the less generous silver-tier coverage), Medicare Part E benefit packages would typically be more comprehensive than most plans sold in the ACA Marketplaces. It would also give Medicare Part D the long-sought authority to negotiate lower prescription drug prices.

FEDERAL AGENCIES

CMS finalizes rule that further waters down ACA consumer protections

The Centers for Medicare and Medicaid Services (CMS) published their final Notice of Benefit and Payment Parameters (NBPP) last week, which set the standards for Affordable Care Act (ACA) Marketplaces in 2019.

The final standards are largely the same as though proposed by CMS last fall (see Update for Week of November 6th). It broadly seeks to “reduce regulatory burdens” relating to ACA mandates and give federal and state agencies greater flexibility in their enforcement, consistent with the President’s first executive order (see Update for Week of January 30th).

One of the most prominent provisions gives states greater authority to define essential health benefit (EHB) packages that individual and small group insurers must offer (delayed under the final rule until 2020). Under the final rule, states may adopt all or part of another state's benchmark EHB plan (or build a new EHB package from scratch), so long as that plan is not too generous and in line with the benefits covered under a “typical employer plan.” However, states still must cover all ten of the EHB categories set forth in the ACA statute (such as prescription drugs).

Another provision that has garnered public attention will make it harder for consumers in states that did not expand Medicaid under the ACA to qualify for premium tax credits to purchase Marketplace coverage. Under the Obama Administration, CMS had “generally” accepted an individual’s attestation of their income if it conflicted with data on file with the Internal Revenue Service (IRS) and the Social Security Administration (SSA). However, in instances where an individual is claiming income higher than IRS or SSA have on file, and that income would make them eligible for premium tax credits, CMS will now require that individual be ineligible for the credits until additional proof of income is provided.

Consumer advocates warned CMS that individuals whose income often fluctuates would be bounced on and off Marketplace coverage under this verification policy (see Update for Week of November 6th).

The NBPP also gives individual market insurers a streamlined process to seek lower medical-loss ratio caps on administrative costs and profits (for up to three years) in order to ensure market stability and eliminates standardized plan options in order to “maximize innovation.” In addition, it increases the default threshold for rate review from ten to 15 percent, meaning that insurer increases in premiums will not be presumed to be excessive (and require actuarial justification) if they are under that threshold.

The final rule will directly impact entities that serve as navigators helping consumers enroll in Marketplace plans. It removes the requirements that each Marketplace have at least two navigator entities with at least one being a “community and consumer-focused nonprofit group.” CMS will also no longer mandate that navigators have a physical presence in the Marketplace service area.

CMS will also no longer handle enrollment functions for the Small Business Health Options Program (SHOP) through www.healthcare.gov, consistent with a proposed change it announced earlier last year (see Update for Weeks of May 15th and 22nd). Eligibility for the small employer tax credit under the ACA will continue to be determined by this web portal for federally-facilitated Marketplaces (FFMs). However, CMS will now allow both small employers and their workers to enroll in SHOP plans directly through an agent or broker (or a SHOP Marketplace created by states).

In another major change, CMS used separate but concurrent guidance to expand the hardship exemption under the ACA’s individual mandate, which remains in effect for 2018 (see Update for Week of December 18th). Under the new policy, consumers who live in counties with no more than one Marketplace insurer will be exempt from any tax penalties for failing to maintain minimum essential coverage they could afford.

The final NBPP confirms that the open enrollment period will continue to run from November 1st through December 15th (after being cut in half under the NBPP for 2018). All qualified health plan (QHP) submissions are due from states by June 20th. The deadline for insurer rate filings has been pushed back one week to July 25th (or July 1st for the handful of states without an effective rate review program).

Maximum annual out-of-pocket limits for 2019 will increase to \$7,900 for individuals and \$15,800 for family coverage.

As with the proposed rule, CMS makes no mention in the NBPP of whether it will require Marketplace insurers to accept third-party premium and copayment assistance from charitable organizations like PSI, the same as they required of federal and state health care programs under a 2014 interim final rule (see Update for Week of June 2, 2014). Under the Obama Administration, the agency had agreed in prior NBPP rules to consider making such a change. However, CMS' failure to move forward on this issue under either the Obama or Trump Administration led Rep. Kevin Cramer (R-ND) to reintroduce legislation (H.R. 3976) that would force HHS to ensure the availability of charitable assistance (see Update for Week of October 2nd). That bill has nearly 140 bipartisan cosponsors.

CMS yet to decide whether insurers will be allowed to “silver-load” premiums for 2019

The Administrator for the Centers for Medicare and Medicaid Services (CMS) confirmed last week that the agency is considering whether to continue allowing states to “silver-load” premiums for the 2019 plan year.

The final Marketplace standards for 2019 (see above) were expected to address the practice of state insurance departments allowing insurers to mitigate the loss of ACA cost-sharing reductions by hiking premiums only for the silver-tier plans to which they were tied (see Update for Week of November 13th). Such “silver-loading” caused the federal government to pay much higher premium tax credits than anticipated (see above), since the amount of the credit was tied to the second lowest-cost silver plan.

As a result, the Congressional Budget Office (CBO) found that “silver-loading” could cause the federal government to pay as much as \$44 billion more in premium tax credits than expected over the next ten years. However, the increase in premium tax credits had the counter effect of actually lowering premiums for those who were subsidy-eligible, with the average premium for subsidized consumers in federally-facilitated Marketplaces dropping from \$106 to \$89 (or 16 percent).

The CMS Administrator acknowledged that in many cases the higher tax credits made more comprehensive gold coverage far more affordable, even quadrupling enrollment in gold-tier plans in some states (see Update for Week of February 12th). However, she emphasized that the agency was “very concerned” that “silver-loading” was dramatically increasing premium costs for those not eligible for premium tax credits, making the most popular silver-tier plans often unaffordable for this group.

HEALTH CARE COSTS

Prescription drug spending slowed last year but shift toward specialty and biologic drugs continued

A new report released last week by IQVIA Institute for Human Data Science found that national spending on prescription drugs climb by only 0.6 percent last year, the lowest annual increase since 2012 when the largest concentration of patent expirations took place.

IQVIA acknowledges that its cost figures trend lower than those annually released by the federal government (which includes intermediary margins and patient copayments). The \$324 billion that they calculated for total drug spending account for manufacturer rebates and discounts. According to researchers, real net per-capita spending actually fell by 2.2 percent when factoring in these allowances along with population and economic growth.

The figures show that manufacturers are starting to realize less revenue than the stated list price for their products, which rose by 1.4 percent last year. Researchers found that the growth in net spending slowed to approximately \$700 million last year, down dramatically from \$12.1 billion in 2016, while sales of new brand-name drugs contributed \$2.3 billion less growth and generics declined by \$5.5 billion.

Researchers stressed that these products contributed less to sales growth because price increases were lower last year than in 2016, both before and after rebates and discounts. Also manufacturers appear to “have modified their pricing strategies to lower the annual list price increases” as price increases on brand-name drugs averaged nearly seven percent last year while net price growth was just under two percent (after rebates and discounts).

The study noted the decline in overall spending and bigger bite that rebates and allowances are taking from list prices may not be resulting in lower out-of-pocket costs to consumers, which have remained largely unchanged overall since 2013. However, consumer costs for specialty and biologic drugs continue to grow as spending continues to shift towards these medications (which represented 37.4 percent and 12.6 percent respectively of all drug spending). Even though only 2.5 percent of all prescriptions in 2017 were for drugs costing more than \$50, these consumers shouldered 41 percent of all patient out-of-pocket costs.

STATES

States continue to advance reinsurance bills with minimal opposition

Legislation to stabilize individual market premiums by compensating insurers for exceptional claims continue to gain bipartisan support and move through state legislatures with minimal opposition.

Reinsurance bills flourished after Alaska, Minnesota, and Oregon receive federal approval last year to create their own programs to replace the temporary reinsurance payments under the Affordable Care Act (ACA) that expired after 2016 (see Update for Week of November 13th). In the cases of Alaska and Minnesota, the state reinsurance programs were credited with dramatically reduced premium increases for 2018 (see Update for Week of December 18th).

Two Democrat-controlled states enacted legislation this week that would authorize their state agencies to seek federal waivers creating such a reinsurance program (see Maryland and New Jersey below). However, reinsurance programs are equally popular among Republican-controlled states as Wisconsin Governor Scott Walker (R) formally submitted federal waiver plan this week after was approved by the legislature (see Update for Week of February 26th), while the Louisiana House and Missouri House also passed comparable authorizing legislation (H.B. 472 and H.B. 2539 respectively). The Maine Bureau of Insurance is prepared to submit their waiver request to reactivate a previous state reinsurance program while Colorado and Michigan are among the roughly one dozen other states considering similar bills.

The reinsurance bills have been strongly backed by state provider groups, consumer organizations, and insurers. They have passed by wide margins with little opposition, despite conservative branding the ACA reinsurance program as an “insurer bailout” and refusing to authorize payments (see Update for Weeks of December 15, 2014).

California

New bill would put safeguards on third-party premium and cost-sharing assistance

The Senate Health Committee advanced legislation last week that would place safeguards on third-party premium and cost-sharing assistance, sending it on to the Appropriations Committee.

The bill introduced earlier this year by Senator Connie Leyva (D) follows federal regulations in requiring that insurers accept such third-party assistance from federal and state health care programs, as well as Native American tribes. However, non-profit charitable organizations and other third-party entities that receive a “direct or indirect financial benefit from the third-party payments” or a “majority of its funding from one more financially interested health care providers” must provide the assistance for a full plan year and ensure it is based on financial need. They must also annually notify the health plan and applicable state agencies that recipients of their assistance are not eligible for Medicare, Medicaid, or the Covered California Marketplace created pursuant to the Affordable Care Act (ACA).

The safeguards largely follow those proposed by the Centers for Medicare and Medicaid Services (CMS), which since 2014 has given Marketplace insurers the discretion to refuse third-party payments from non-profit organizations (see Update for Week of June 2, 2014). PSI is supporting Congressional legislation backed by nearly 140 bipartisan cosponsors (H.R. 3976) that would force CMS to insurers to accept non-profit assistance, the same as they must do for federal and state programs (subject to such safeguards).

The California bill (S.B. 1156) is backed by Blue Shield of California, which paid out more than \$64 million in third-party assistance from 2014-2016. The largest lobby group for insurers, America's Health Insurance Plans (AHIP), has also backed the additional safeguards to prevent "conflicts of interest", though stressed this week that they should not impede the legitimate and necessary role that charities provide to high-cost subscribers who would otherwise be unable to access coverage and care.

One of the bill's loudest supporters is the Service Employees International Union, which is focused on preventing "steering" of dialysis patients to higher-reimbursing private plans in order to maximize "outsized profits". The group plans to put a measure on the November ballot that would cap revenue collected by dialysis companies at 15 percent above the cost of patient care.

Inspector General says up to ten percent of Medicaid expansion enrollees may not be eligible for coverage

The Inspector General for the U.S. Department of Health and Human Services (HHS) has concluded that California's expansion of Medicaid under the Affordable Care Act (ACA) may have improperly enrolled up to 450,000 applicants who should have been ineligible for coverage.

California is by far the largest of the 31 states that participate in the ACA's Medicaid expansion, which increased Medi-Cal enrollment by 57 percent (or nearly 4.5 million enrollees). However, with up to ten percent of that total potentially ineligible, the state could have made more than \$1 billion in improper payments for that group.

State officials accepted the Inspector General's findings of deficiencies in its electronic system to verify eligibility and insisted that computer upgrades had already taken place following the 2015 audit period, during which Medi-Cal struggled with a backlog of more than 900,000 applications. However, it stressed that the report's conclusions were based on a sample of only 150 enrollees, which the Inspector General then tried to extrapolate to the entire expansion population. Even the conservative-leaning American Enterprise Institute, which opposes the ACA expansion, conceded that a "more robust analysis" was needed in order to conclude that Medi-Cal is "systemically making enrollment errors."

The federal Centers for Medicare and Medicaid Services (CMS) has yet to determine whether Medi-Cal will need to refund an overpayment of ACA matching funds for expansion enrollees who were not eligible.

Colorado

Committee rejects work requirement and lifetime cap for Medicaid enrollees

The Senate Health and Human Services failed to advance legislation late last month that would have required "able-bodied adults" on Medicaid to be actively seeking employer or job training, imposed monthly verification requirements on income, and capped Medicaid eligibility at no more than five years.

S.B. 214 was sponsored by Senator Larry Crowder (R) following the Trump Administration's approval of Medicaid work requirements in three states and pending requests by other states to impose comparable work requirements or lifetime caps (see Update for Week of March 19th). However, the measure immediately drew staunch opposition from Medicaid enrollees, providers, and Democratic lawmakers and failed to garner sufficient support in the Republican-controlled committee.

A new analysis released this week by the PricewaterhouseCoopers (PwC) Health Research Institute concluded that Medicaid work requirements proposed in ten states could impact more than 1.7 million enrollees, or about half of the Medicaid population in each state.

New bill would study feasibility of Medicaid buy-in option for mid-to-lower income consumers

First-term Representative Dylan Roberts (D) introduced legislation last week that would require the Department of Health Care Policy and Financing and the Division of Insurance to study the costs, benefits, and feasibility of giving lower-income Coloradans the option of buying-in to the Medicaid program.

Several states are considering Medicaid buy-in options that build upon the model 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). It would specifically let consumers receiving premium tax credits under the ACA use those subsidies to purchase Medicaid coverage instead of private plan coverage in ACA Marketplaces. Both chambers of the New Mexico legislature approved such a plan earlier this year but they did not advance before the close of session (see Update for Week of January 22nd).

In addition to the Medicaid buy-in, H.B. 1384 would make the agencies report by February 15th on whether the state should instead pursue a public-private partnership option such as the Children's Basic Health Plan or a regionally-based cooperative health plan affiliated with a private carrier. The bill was assigned to Health, Insurance, and Environment Committee.

Indiana

White House approves CMS request to limit evaluations of Medicaid expansion alternative

The White House Office of Management and Budget (OMB) granted the Centers for Medicare and Medicaid Services (CMS) permission last week to cut back on its efforts to evaluate whether Indiana's alternative to the Medicaid expansion under the Affordable Care Act (ACA) harmed access to care.

Under the Obama Administration, CMS has granted federal waivers for eight states to pursue "private sector" alternatives, where ACA matching funds for the expansion were used by states to purchase coverage for newly-eligible Medicaid enrollees in private Marketplace or Medicaid managed care plans.

The Healthy Indiana Plan 2.0 waiver obtained by then Governor Mike Pence (R) allowed residents just above standard Medicaid eligibility to make contributions to health savings accounts (HSA) that pay premiums and cost-sharing for private coverage through Medicaid managed care plans (see Update for Weeks of January 26, and February 2, 2015). However, it also allowed "lock-out periods" which let Indiana terminate Medicaid coverage for more than 91,000 expansion enrollees if they failed to submit required paperwork, while another 25,000 were dropped for failing to timely pay premiums.

The Obama Administration allowed the lock-out period so long as CMS collected data from current and former HIP 2.0 enrollees about how the lock-outs impacted their access to care. The survey specifically sought information on what caused their termination of coverage, whether they were able to promptly secure other forms of coverage, and whether the termination disrupted or prevented their care.

However, under the Trump Administration, CMS asked for and received permission from OMB to scale back this survey and exclude any information from former HIP 2.0 enrollees. The decision by the White House comes only two weeks after the Government Accountability Office issued a report criticizing CMS for failing to ensure programs launched under similar Section 1115 demonstration waivers were adequately evaluated.

Iowa

Governor signs bill allowing dominant insurer to offer “junk” plans that do not comply with ACA

Governor Kim Reynolds (R) signed legislation this week allowing self-funded plans that Wellmark Blue Cross and Blue Shield offers to the Iowa Farm Bureau to circumvent consumer protections under the Affordable Care Act (ACA).

The measures (H.F. 2364/S.F. 2329) effectively create a “parallel insurance market” for low-cost, limited benefit plans that are not deemed to be insurance. They are modeled after those offered to the Tennessee Farm Bureau, which pre-dated the ACA and were “grandfathered” and allowed to continue once the ACA went into effect.

Iowa Democrats have pledged to ask the Trump Administration to block the new law. However, because the Obama Administration never required the Tennessee Farm Bureau plans to come into compliance with the ACA, most commentators expect the Trump Administration to likewise allow the Iowa Farm Bureau plans, even it recently blocked an effort by the Idaho Insurance Department to let its dominant insurer offer similar limited-benefit and non-ACA compliant plans in the individual market (see Update for Week of March 12th). However, they note that the Idaho plans were still defined as “insurance”, thereby incentivizing other states wanting to evade the ACA to simply label their non-compliant plans as anything but “insurance.”

The bills also allow small businesses or self-employed individuals to band together to buy coverage through “association health plans” (AHPs) that do not comply with the ACA, pursuant to proposed regulations issued earlier this year by the Trump Administration (see Update for Week of January 8th). However, the federal rules define AHPs as insurance while the Iowa bills do not.

Opponents of the bills include Medica, the lone Marketplace insurer offering statewide coverage last year. They insist that allowing the non-ACA compliant “junk” plans, even just for Farm Bureau members, will siphon away the critical young adult demographic from the ACA Marketplace, effectively driving up premiums for Marketplace consumers who will be left in a risk pool more skewed towards costlier consumers. Iowa’s Marketplace consumers already faced the highest premium spike in the nation this year (88 percent on average for “benchmark” silver plans) and a skewed risk pool could put further upward pressure on premiums even as the state’s dominant insurer Wellmark returns to the Marketplace for 2019 (see Update for Week of February 12th).

Those enrolled in the new Farm Bureau or AHP plans will still be subject this year to the ACA tax penalty for not maintaining essential health coverage they could afford, even though the “individual mandate” penalties have been repealed by Congress starting in 2019 (see Update for Week of December 18th).

Kentucky

Class-action lawsuit challenging Medicaid work requirements will not be heard in Kentucky

A federal judge ruled this week that a class-action lawsuit challenging Medicaid work requirement federally-approved for Kentucky will be heard in the U.S. District Court for the District of Columbia.

Earlier this year, Governor Matt Bevin (R) made Kentucky the first state to impose Medicaid work requirements on all “able-bodied” adults of working age, a move that he estimates will end coverage for roughly 95,000 enrollees (see Update for Week of January 8th). At least 16 Medicaid enrollees promptly filed suit in the D.C. federal court alleging that the Governor and Centers for Medicare and Medicaid Services (CMS) lacked the authority to approve work requirements, which previous Administrations believed to violate federal Medicaid law (see Update for Week of January 22nd).

In response, Governor Bevin issued an executive order threatening to terminate the state’s entire Medicaid expansion under the ACA (which was enacted by his Democratic predecessor) if the Obama-appointed judge in the D.C. case struck down his work requirements. The Governor subsequently filed a countersuit against the D.C. plaintiffs in the U.S. District Court for the Eastern District of Kentucky, where all but one judge was appointed by Republican presidents.

The Trump Administration defended the Governor's actions and asked the D.C. court to simply transfer the class-action case to the Eastern District of Kentucky. However, Judge James Boasberg noted that over one dozen other states are seeking to follow Kentucky's lead on the work requirements and ruled that the case would thus properly be heard in D.C. given its "national consequences".

The Eastern District of Kentucky has yet to decide whether to dismiss the Governor's countersuit.

Louisiana

New bill seeks to ensure lower drug cost-sharing for ACA-compliant plans

Senator Fred Mills (R), chair of the Health and Welfare Committee, introduced new legislation earlier this month that would require insurers that offer qualified health plans (QHP) complying with the Affordable Care Act (ACA) to offer at least one plan in each metal tier that does not require an enrollee to pay a prescription drug deductible or pay more in co-pay or coinsurance than the amount specified in the summary of benefits.

The bill (H.B. 517) would not apply to QHPs offered under the lowest bronze tier or catastrophic plans, nor would it apply to health savings accounts. It also would not require an insurer to offer a QHP in any particular metal tier or more than one metal tier.

Maryland

Appeals court strikes down new law to prohibit prescription drug price gouging

The U.S. Fourth Circuit Court of Appeals ruled last week that Maryland's new law to prohibit price-gouging by prescription drug manufacturers was unconstitutional.

Governor Larry Hogan (R) had let H.B. 631 become law last year without his signature, despite siding with pharmaceutical claims that it was "overbroad" and "unconstitutional" (see Update for Weeks of May 29th and June 5th). The Association for Accessible Medicines (formerly the Generic Pharmaceutical Association) immediately sued to block the law from going into effect but was rebuffed the U.S. District Court for the District of Maryland (see Update for Week of October 2nd).

In a 2-1 ruling, a three-judge panel on the appellate court overturned the lower court's ruling and ordered it to grant the injunction sought by AAM, concluding that the state of Maryland could not regulate out-of-state drug transactions under the Commerce Clause to the U.S. Constitution. (The prevailing judges were appointed by Presidents Obama and George W. Bush.)

The Maryland law was the first of its kind in the nation and several other states including Colorado, Illinois, Louisiana, and New Hampshire were considering comparable prohibitions (see Update for Week of February 26th). Maryland's law applied only to sales of essential off-patent or generic drugs and gave the Attorney General authority to demand that generic manufacturers or wholesale distributors produce documentation proving that an increase in price is not "unconscionable" and issue rebates to consumers. Under the measure, the health department would notify the Attorney General whenever three or fewer manufacturers are actively manufacturing and marketing an essential off-patent drug, the wholesale acquisition cost (WAC) increases by 50 percent or more in one year, or if the WAC for a 30-day supply exceeds \$80 (see Update for Weeks of May 29th and June 5th).

Governor signs bill that uses tax reform savings to fund reinsurance payments for insurers

Governor Larry Hogan (R) signed several measures last week intended to stabilize health insurance premiums in the Maryland Health Care Exchange.

The first bill (H.B. 1795/S.B. 1267) would make Maryland the latest state (see above) to create a reinsurance program for insurers. The program would compensate insurers who incur exceptional claims, similar to the temporary reinsurance payments under the Affordable Care Act (ACA) that expired after 2016. If the required waiver is approved by the Trump Administration, Maryland would be the first state to use roughly \$380 million that health insurers reaped under the federal tax reform bill (see Update for Week of December 18th) to help fund these payments.

Average premiums for 2018 had spiked in the Exchange, increasing for silver-tier plans by 52 percent for the dominant carrier CareFirst BlueCross BlueShield and 22 percent for Kaiser Permanente. An additional 21-27 percent was tacked onto silver plans following the Trump Administration's elimination of ACA cost-sharing subsidies (see Update for Week of November 13th). Exchange officials had warned that the individual health insurance market in Maryland could "collapse" due to another average premium hike of up to 50 percent expected for 2019, due partly to the Congressional repeal of ACA individual mandate penalties (see Update for Week of December 18th).

Reinsurance approved last year for Alaska and Minnesota have dramatically reduced premium increases in those states (see Update for Week of March 19th). The waiver application has already been approved by exchange officials, who will hold four public hearings over the coming weeks.

A second bill (S.B. 387) would impose a 2.75 percent assessment on insurers that could be used by the Exchange for reinsurance payments or other state efforts to stabilize the individual market.

House and Senate bills that would have created a state alternative to the ACA's individual mandate (H.B. 1167/S.B. 1011) have both stalled in committee.

New Jersey

Governor expected to signs bills creating individual health insurance mandate, reinsurance program

New Governor Phil Murphy (D) is expected to sign legislation passed by the House and Senate this week that seeks to stabilize health insurance premiums in the individual market by creating an alternative to the individual mandate under the Affordable Care Act (ACA) and compensating insurers for exceptional claims.

A.3380 and S.1878 passed each of the Democratically-controlled chambers by sizeable margins. A.3380 would extend the individual mandate under the ACA once its tax penalties are repealed in 2019 (see Update for Week of December 18th). It would makes New Jersey the first state to enact its own replacement to the ACA following the Congressional repeal (Massachusetts already has an individual mandate upon which the ACA version was modeled).

Polling by Rutgers University showed that only 40 percent of New Jersey consumers support a state alternative to the individual mandate. However, lawmakers cited projections from the Congressional Budget Office and other private consultants showing that its repeal could result in premiums spiking by more than ten percent for 2019.

At least ten other states are considering legislation to create comparable versions of the ACA's individual mandate, in order to ensure insurer risk pools are adequately balanced between sicker and healthier consumers (see Update for Week of March 19th). The Vermont House passed H.696 last month and it was approved by the Senate Finance Committee this week. The Hawaii Senate approved S.B. 2924 last month and has passed two House committees. However, similar measures have stalled in both Connecticut (see Update for Week of March 19th) and Maryland (see above).

The second bill (S.1878) would authorize state agencies to seek a waiver allowing New Jersey to become the fourth state with federal approval to create a reinsurance program. Similar programs have dramatically reduced premiums in Alaska and Minnesota (see Update for Week of March 19th) by providing additional payments for insurers who incur an exceptionally high-cost claims in a given year. They are intended to replace the temporary reinsurance payments under the ACA that expired after 2016.

If the legislature had not taken action to stabilize the individual marketplace, an analysis completed last week for Covered California predicted that New Jersey consumers would see premium increases averaging 32 percent next year and 90 percent over the next three years (see Update for Week of March 19th).

Ohio

Insurance department seeks first-ever federal waiver from ACA individual mandate

The Department of Insurance (DOI) is seeking to use the State Innovation Waiver process under Section 1332 of the Affordable Care Act (ACA) to opt-out of the law's requirement that everyone purchase health insurance they can afford.

The tax reform legislation signed by President Trump zeroes out all tax penalties under the individual mandate for 2019, but the mandate itself remains on the books. As a result, DOI insists that the mandate should be formally waived, even though it acknowledges that an analysis by Oliver Wyman actuaries showed that the waiver would not have any impact on Ohio consumers.

DOI's application predicts that individual market enrollment will fall 19 percent by 2022 as a result of the tax penalty repeal, while average monthly premiums will jump by nearly 22 percent over that time.

Agency order frees pharmacists to tell consumers when drugs are cheaper without insurance

The Department of Insurance issued a new bulletin on April 4th prohibiting "gag orders" from insurers and pharmacy benefit managers (PBMs) that prevent pharmacies from notifying consumers when a prescription drug purchase would be less expensive without using their health insurance.

The bulletin, which immediately took effect, also bars insurers and PBMs from charging consumers more for prescription drugs than what it would otherwise cost without insurance.

Utah

Medicaid expansion voter initiative likely to be placed on November ballot

The Utah Decides Healthcare advocacy group announced this week that it has submitted its request for citizen ballot initiative this fall that would make Utah the 33rd state to expand Medicaid under the Affordable Care Act (ACA).

The group gathered more than 165,000 signatures by the April 16th deadline. If 113,000 of these signatures are determined by county clerks to be valid, the initiative would be certified by the Lt. Governor and placed on the November 2018 ballot.

If passed by the voters, the initiative would raise the state sales tax by 0.15 percent in order to fund the state share of costs (which phases up to ten percent starting in 2020). It would expand coverage to roughly Utahns under age 65 who earn up to 138 percent of the federal poverty level (the ACA threshold).

Governor Gary Herbert (R) supported the traditional expansion (see Update for Week of July 25, 2016) but was ultimately forced by conservative lawmakers to sign legislation last month that would only partially expand Medicaid for roughly 70,000 Utahns under age 65 who earn up to 100 percent of poverty and impose work requirements on those made newly-eligible (see Update for Week of March 19th). Such a partial expansion would require approval of a federal waiver that the Obama Administration had previously refused to grant (see Update for Weeks of October 5 and 12, 2015).

According to polling commissioned by Utah Decides Healthcare, the ballot initiative has the approval of 60 percent of Utahns, thanks largely to the support from a majority of the state's Mormon community. The initiative is also backed by most provider and consumer groups, including AARP Utah.

Maine became the first state earlier this year to enact its Medicaid expansion through a voter referendum (see Update for Week of November 6th). Voters in several other states including Idaho, Missouri, Nebraska, and South Dakota may have a similar opportunity this fall if similar signature drives are successful.

Virginia

Medicaid expansion gains Republican support at start of special session

The House of Delegates approved a revised state budget this week that would expand Medicaid eligibility under the Affordable Care Act (ACA) to about 400,000 low-income adults.

The two-year budget plan is largely the same as the House passed during the regular session (see Update for Week of February 12th). However, the House and Senate remained at odds over how or if to expand Medicaid, forcing Governor Ralph Northam (D) to call a special session to resolve the stalemate (see Update for Week of March 19th).

Medicaid expansion had been a non-starter among conservative lawmakers until Republicans lost their House supermajority last fall, hanging onto the chamber only after a coin flip (see Update for Week of January 22nd). However, the Medicaid expansion momentum that the election generated in the House has yet to translate to the Senate, where Republicans also hold only a one-seat majority.

The new budget would require the support of at least two Senate Republicans, since Lt. Governor Justin Fairfax (D) cannot break a tie on budget bills. In an effort to court conservative support, House Speaker Kirkland Cox (R) agreed to strengthen work requirements that the budget would impose on "able-bodied" Medicaid enrollees under age 65.

Senator Frank Wagner (R) indicated this week that he may support the expansion with onerous work requirements, but wants the \$307 million in projected savings to go towards a \$250 per year tax credit to help middle-income Virginians afford their premiums and cost-sharing. Senator Emmett Hanger (R), who has supported past expansion proposals, was also inclined to support an expansion plan so long as funding mechanism proposed by the House (a hospital assessment) was modified. Senate Majority Leader Thomas Norment (R), a staunch Obamacare critic, appeared to acknowledge the inevitability of the Medicaid expansion, but insisted this week that it be part of a "collaborative process" based on conservative principles.

Washington

Marketplace dramatically lowers insurer assessment for 2019

Washington Healthplanfinder officials announced this week that its assessment on participating insurers will drop from \$7.46 to \$3.36 per member per month for all 2019 health plans purchased through the health insurance Marketplace created pursuant to the Affordable Care Act (ACA).

Healthplanfinder officials directed carriers to pass the dramatic 55 percent reduction directly on to consumers through lower premiums, citing the 66 percent spike in average premiums that occurred for 2018 following the Trump Administration's elimination of ACA cost-sharing reductions (see Update for Week of November 13th). However, the Healthplanfinder still experienced record enrollment for this year (See Update for Week of March 19th) enabling it to cut fees for insurers in an effort to make coverage more affordable.