

Health Reform Update – Week of May 28, 2018

CONGRESS

CBO predicts 15 percent average increase in premiums due to junk plans and loss of individual mandate

The Congressional Budget Office (CBO) issued revised projections last week, which predicted that premiums for “benchmark” plans under the Affordable Care Act (ACA) will increase by 15 percent in 2019 (and seven percent in subsequent years) due largely to the Congressional repeal of the tax penalty under the individual mandate (see Update for Week of December 18th).

“Benchmark” plans are the second-lowest cost silver-tier plans. Because they are the plan upon which ACA premium tax credits are calculated, they are by far the most popular plan chosen by enrollees.

The double-digit increase follows the dramatic 34 percent spike for 2019 that occurred due to the President’s elimination of ACA cost-sharing reductions (CSRs), less strict enforcement of the individual mandate, and increase in counties with only one Marketplace insurer (see Update for Week of November 13th).

CBO had previously projected that 30 million consumers would lose coverage by 2028 due to higher premiums and the individual mandate repeal. However, that estimate was raised to 35 million after the Trump Administration sought to allow an influx of limited-benefit plans that need not comply with the ACA (see Update for Week of February 26th).

Republican leaders eye CREATES Act compromise after FDA calls out drugmakers who block generics

The Food and Drug Administration (FDA) publicized a list of 41 manufacturers of name-brand drugs last week that it claims have blocked access to drug samples in order to obstruct the development of lower-cost generic competition.

The list cites instances of manufacturers improperly using Risk Evaluation and Mitigation Strategy (REMS) requirements to restrict access to samples of branded drugs that are necessary to conduct FDA-required tests to demonstrate bioequivalence. The FDA also claims that the manufacturers placed restrictions in commercial agreements that limit the ability of distributors, wholesalers, or specialty pharmacies to sell samples. FDA Commissioner Scott Gottlieb said the agency has referred cases to the Federal Trade Commission (FTC).

The FDA’s action came on the heels of the drug pricing blueprint released last week by President Trump (see Update for Week of May 7th) that seeks to boost competition from generics. Both House Speaker Paul Ryan (R-WI) and Senate Judiciary Committee chairman Charles Grassley (R-IA) indicated this week that they may seek to move *CREATES Act* legislation backed by generic drugmakers (S. 974) that would allow them to sue brand-name drug manufacturers over these “gaming tactics”, but only in exchange for the drugmakers support of the President’s drug pricing plan. Senator Grassley also renewed his call for “pay to delay” legislation long-sought by the FTC that would limit the ability of brand-name and generic drugmakers to enter into patent infringement lawsuit settlements that agree to delay introduction of lower-cost generics (see Update for Weeks of January 11 and 18, 2016), even though that was not part of the President’s blueprint.

President Trump announced this week that drug manufacturers have agreed to voluntarily reduce their prices in the coming weeks by a “massive” amount, but did not provide any details on which manufacturers or drugs were involved.

FEDERAL AGENCIES

Actuary warned CMS that short-term health plans would spike Marketplace premiums and lower enrollment

The chief actuary for the Centers for Medicare and Medicaid Services (CMS) warned this week that the Trump Administration's plan to remove restrictions on short-term health plans would increase federal costs more than initially projected.

The Obama Administration had limited short-term plans to a duration of no more than three months (see Update for Week of June 20, 2016) in order to push younger and often healthier consumers into comprehensive plans that complied with the Affordable Care Act (ACA), thereby ensuring that insurer risk pools were not skewed towards older and more costly subscribers. However, the Department of Health and Human Services (HHS) issued proposed regulations earlier this year that would return short-term health plans to the pre-ACA limit of 364 days, effectively allowing insurers to skirt ACA prohibitions on limited benefits, annual and lifetime caps, and raising premiums based on gender or health status simply by offering plans that terminated before a full year (see Update for Week of February 26th).

The Trump Administration had argued that only 200,000 consumers would enroll in short-term plans next year. However, in a report dated April 6th but not released by CMS until last week, the actuary had actually predicted that 1.4 million consumers would enroll in short-term plans in 2019 (rising to 1.9 million by 2022). Furthermore, the actuary specifically warned CMS officials that the move towards short-term coverage would cause those left in ACA Marketplace coverage to be "less healthy" and more costly, forcing insurers to increase premiums to such an extent that premium tax credits paid by the federal government would increase by \$1.2 billion in 2019 and \$38.7 billion over ten years.

The Urban Institute released an earlier analysis concluding that the expansion of short-term coverage proposed by the Trump Administration would increase the number of people without minimum essential coverage by 2.6 million in 2019, up to 36.9 million. Of this amount, 32.6 million would be completely uninsured and 4.3 million would enroll in expanded short-term coverage.

The Urban Institute study found that the combination of repealing the tax penalties for the individual mandate and expanded short-term coverage would cause premiums for ACA-compliant coverage to spike by 18.2 percent, thus increasing federal spending on ACA premium tax credits by 9.2 percent.

Uninsured rate climbs nearly three percent under the Trump Administration

A new study released earlier this month by The Commonwealth Fund shows that the percentage of working age adults lacking health insurance has increased by nearly three percent since President Trump assumed office.

The increases from 12.7 percent in 2016 to 15.5 percent in 2018 translates to roughly four million Americans aged 19-64 who have lost coverage. Researchers found that the increase was most severe in the 18 states that had not expanded Medicaid under the Affordable Care Act (ACA), where the percentage of uninsured working-age adults shot up nearly six percent to 21.9 percent.

According to the study, Texas continues to lead the nation, with roughly 4.5 million uninsured adults and children and an uninsured rate for working-age adults approaching 30 percent (up from 23 percent in 2016). The second closest state, Oklahoma, stands at 20 percent, which is actually a five percent improvement from 2016. Massachusetts, which has an individual mandate that preceded the ACA, continues to have the lowest uninsured rate for working-age adults at only four percent, followed closely by Hawaii at five percent.

The Commonwealth Fund predicts that an additional five percent of insured adults are likely to drop coverage once the Congressional repeal of the tax penalty under the ACA individual mandate goes into effect (see Update for Week of December 18th).

Cancer group sues HHS to block sequester cut to Medicare Part B drugs

The Community Oncology Alliance (COA) filed a lawsuit this week in the U.S. District Court for the District of Columbia seeking to block the Trump administration from applying the two percent sequester cut imposed by the *Budget Control Act of 2011* (see Update for Week of August 1, 2011) to reimbursement for drugs paid under Medicare Part B.

The Department of Health and Human Services started applying the sequester to all Part B reimbursement in 2013 and plans to do so through 2027, absent Congressional intervention. COA insists that the sequester has directly forced at least 135 independent community cancer clinics to close, while 190 others have been acquired by hospitals. The group claims that the consolidations imposed at least \$2 billion in additional costs on Medicare in 2014 alone, increasing beneficiary coinsurance by \$500 million for that year.

COA argues that the application of the sequester cut to Part B drug payment is “both illegal and unconstitutional” Congress set reimbursement at average sales price (ASP) plus 6 percent in the *Medicare Modernization Act of 2003*. The sequester effectively amends this statutory threshold by lowering the payment to ASP plus 4.3 percent, a move COA contends cannot be done by HHS without specific Congressional authorization.

FDA to fast-track certain gene therapy approvals, starting with hemophilia

The Food and Drug Administration (FDA) announced last week that it will create a streamlined approval path for certain gene therapies

The agency approved the first three gene therapies last year for rare forms of blood cancer and blindness. They are an experimental treatment that replace genetic material into cells to compensate for abnormal genes or to make a beneficial protein in an effort to cure certain disorders.

Despite their promise, the FDA has been initially reluctant to approve gene therapies after early trials showed potentially serious health risks including toxicity, inflammation, and cancer. They also carry an enormous price tag, with the first gene therapies costing nearly \$500,000 per year.

However, Commissioner Scott Gottlieb stated that the agency wanted to eliminate the “arduous” review that manufacturers faced in bringing these potential cures to market and will soon release a “comprehensive policy framework” for how companies can receive an expedited approval from the FDA for “devastating diseases” which “lack available therapy.” This fast-track process would allow for FDA approval if a product shows significant benefit before all clinical trials have been completed, so long as the trials are continued after the drug is on the market.

Gottlieb revealed that hemophilia would be the first disorder that the FDA will target with this new expedited process because “it’s an area of a lot of development activity” where emerging gene therapies have already shown potential benefit. As a result, he identified it as a field where the FDA has “traditionally been willing to accept more uncertainty to facilitate timely access to promising therapies.”

STATES

California

Covered California predicts double-digit premium increase and enrollment drop

Covered California released new estimates last week showing that average premiums for the Affordable Care Act (ACA) Marketplace are likely to rise by 11 percent in 2019 while overall enrollment will fall by 12 percent.

Officials for the nation’s largest Marketplace attribute the negative projections to Congress’ elimination of tax penalties for those who do not purchase minimum essential coverage they can afford (see Update for Week of December

18th), as well as the Trump Administration's allowance for lower-cost but limited-benefit health plans that fail to comply with ACA consumer protections (see Update for Week of February 26th). Their findings are consistent with projections from the Congressional Budget Office showing that both actions are likely to siphon away healthier and less-costly consumers and skew the Marketplace pools toward sicker and more costly consumers, thereby increasing average premiums for all Marketplaces by roughly 15 percent (see above).

As a result of the loss of the individual mandate and prevalence of limited-benefit plans, the chief actuary for the Centers for Medicare and Medicaid Services now projects that up to 1.4 million consumers will purchase short-term health plans in 2019, dramatically more than the 200,000 initially predicted by CMS officials (see above).

Final Covered California premiums will be released in July. However, the projected 11 percent increase is far less drastic than proposed hikes in states like Maryland, where insurers are requesting average premium hikes of 30 percent (see Update for Week of April 16th).

Senate passes bills that would prohibit short-term and association health plans

The Senate passed S.B. 910 and S.B. 1375 this week, making California one of a handful of states taking action against proposed federal regulations that would let short-term and/or association health plans circumvent the Affordable Care Act (ACA).

The Obama Administration had limited short-term plans to a duration of no more than three months (see Update for Week of June 20, 2016) in order to push younger and often healthier consumers into comprehensive plans that complied with the Affordable Care Act (ACA), thereby ensuring that insurer risk pools were not skewed towards older and more costly subscribers. However, the federal Department of Health and Human Services (HHS) issued proposed regulations earlier this year that would return short-term health plans to the pre-ACA limit of 364 days, effectively allowing insurers to skirt ACA prohibitions on limited benefits, annual and lifetime caps, and raising premiums based on gender or health status simply by offering plans that terminated before a full year (see Update for Week of February 26th).

State law is silent on the definition of short-term health insurance. As a result Senator Ed Hernandez (D), a physician who chairs the Health committee, sponsored S.B. 910, which would explicitly ban any plan that expires in less than 365 days (starting in 2019), by far the broadest restriction sought by any state (see Colorado and Hawaii below).

The bill passed with only ten dissenting votes and was supported by a broad range of consumer groups and insurers (including Blue Shield of California and Kaiser Permanente). However, Anthem Blue Cross continues to oppose S.B. 910 and supports the Trump Administration's extension of short-term plans for up to 364 days.

The Senate later passed S.B. 1375 (also sponsored by Senator Hernandez) with similar support, which would require association health plans (AHPs) sought by the Trump Administration to comply with all ACA consumer protections. Under regulations proposed by the U.S. Department of Labor (DOL), trade associations to sell policies across state lines that no longer need to comply with certain ACA consumer protections, like essential health benefits or prohibitions on raising premiums based on gender or health status (see Update for Week of January 8th). DOL estimated that up to 11 million Americans who are self-employed or work for small business could benefit under these AHPs (that would be organized by a geographic area or industry), although Avalere Health and the D.C. Health Benefit Exchange warned that they could cause premiums for ACA-compliant plans to spike as younger and healthier consumers leave the Marketplaces (see Update for Week of April 16th). America's Health Insurance Plans (AHIP) predicted last week that average premiums would increase by up to 5.7 percent next year as a result of both short-term and association health plans.

Legislature advances package of health insurance affordability measures before key legislative deadline

The Assembly and Senate passed a slew of measures this week intended to make individual health insurance more affordable for low-to-moderate income Californians.

The measures were required to clear their chamber of origin by June 1st in order to be considered this year. The bills that met this threshold include:

- S.B. 1021, which would maintain the annual caps on prescription drug copayments past the 2020 sunset set by prior legislation, which required insurers to limit cost-sharing to no more than \$250 for a 30-day supply of an individual prescription, or \$500 for bronze tier plans as defined by the Affordable Care Act (ACA) (see Update for Weeks of October 5 and 12, 2015). S.B. 1021 bill also prevents insurers from using more than four cost-sharing tiers for prescription drugs.
- S.B. 1255, which would require Covered California to administer a state-funded premium assistance program that would offer premium assistance to low-to-moderate income consumers, but give priority to those whose premiums costs more than eight percent of their annual household income. There is no upper-income limit for premium assistance but cost-sharing subsidies would only be available to those earning less than 400 percent of the federal poverty level (FPL).
- A.B. 2565, which would provide additional state-funded premium assistance to the 1.2 million Covered California consumers who currently receive premium tax credits under the Affordable Care Act (i.e. those earning 100-400 percent of FPL).
- A.B. 2459, which would ensure that Californians earning 400-600 percent of FPL spend no more than eight percent of their annual household income on premiums by providing refundable personal income tax credits towards premiums for those earning above the ACA threshold for premium tax credits (400 percent of FPL).
- A.B. 2499, which would increase the ACA medical-loss ratios so that individual and small group insurers would have to spend at least 85 percent of premium revenue on direct medical care (instead of 80 percent) or refund the difference to consumers.
- A.B. 2427, which would require managed care plans participating in Medi-Cal to negotiate with Covered California to offer Marketplace coverage in any rural county that has two or fewer insurers.
- S.B. 1108, which would prohibit any state agency from pursuing federal waiver that make it harder to enroll in Medi-Cal. This specifically includes the work requirements, lifetime limits, waiting periods, or lock-out periods that have been sought by conservative-leaning states (see Update for Week of May 7th).

However, the Senate also advanced a measure opposed by PSI and other non-profit charitable foundations that would prevent them from providing premium assistance to low-to-moderate income consumers that are based on diagnosis (S.B. 1156). Although the legislation is billed as a consumer protection measure, this “safeguard” goes beyond those proposed by the federal government and would have the unintended effect of preventing those with the costliest of disorders from receiving charitable assistance to afford their coverage (see Update for Week of May 7th). Under the bill, insurers could continue to refuse premium assistance from charitable groups even if they comply with all of the new safeguards, including providing assistance for a full plan year and notifying applicants of all available coverage options.

The Assembly Appropriations Committee held back one of the most high-profile and contentious bills this session, which would have set a ceiling on private insurer payments to hospitals, physicians, and other providers, as well as cap consumer out-of-pocket costs at the insurer cost-sharing amount and create a global budget for all state health care spending. A.B. 3087 was supported by consumer groups and the California Labor Federation but drew strong opposition from state hospital and medical associations.

Colorado

Draft regulations would limit the use of short-term plans proposed by the Trump Administration

The Department of Regulatory Affairs has released draft regulations that would impose new limits on short-term health plans permitted by the Trump Administration.

The Obama Administration had limited short-term plans to a duration of no more than three months (see Update for Week of June 20, 2016) in order to ensure that younger and often healthier consumers were purchasing comprehensive plans that complied with the Affordable Care Act (ACA), thereby ensuring that insurer risk pools were not skewed towards older and more costly subscribers. However, the federal Department of Health and Human Services (HHS) issued proposed regulations earlier this year that would return short-term health plans to the pre-ACA limit of 364 days, effectively allowing insurers to skirt ACA prohibitions on limited benefits, annual and lifetime caps, and raising premiums based on gender or health status simply by offering plans that terminated before a full year (see Update for Week of February 26th).

Maryland Governor Larry Hogan (R) recently signed legislation that would limit short-term plans to no more than 90 days and prevent their renewal (H.B. 1782). Vermont enacted a comparable law (H.892) although no short-term plans are currently offered in the state.

Pending legislation in several other states including California (see above), Hawaii (see below), and Illinois (H.B. 2624 was sent this week to the governor) would put similar restrictions on short-term plans in order to prevent the spike in premiums that the Congressional Budget Office, the Centers for Medicare and Medicaid Services actuary, Avalere Health, and the Urban Institute predict if healthier consumers are allowed to purchase limited-benefit plans that do not comply with the ACA (see above). However, legislative efforts to limit short-term coverage has already failed in Minnesota and Missouri.

The Washington insurance commissioner has also announced plans to limit short-term plans through regulation.

Connecticut

Governor signs “groundbreaking” drug pricing transparency legislation

Governor Dannel Malloy (D) signed legislation this week that would require prescription drug manufacturers to publicly justify price increases of at least 20 percent in one year or 50 percent over three years.

H.B. 5384 was authored by Rep. Sean Scanlon (D), House chair for the Joint Insurance and Real Estate Committee. He called the measure “groundbreaking” as it makes Connecticut the first state to mandate that pharmacy benefit managers (PBMs) disclose rebates they receive from drug manufacturers, as well as the amount of rebate they passed onto consumers (versus the amount they retained). It also requires PBMs to report their administrative fees, including any other payments by the manufacturer to the PBM that are not considered rebates. (Louisiana Governor John Bel Edwards (D) did sign S.B. 283 last week which imposed comparable PBM requirements for his state).

Other provisions force insurers to include information on the top 25 highest cost drugs, top 25 drugs with greatest increases, and the portion of premium that increased because of drug spending on plan when they file proposed rates with the Insurance Department. A similar requirement is part of most of the drug pricing transparency laws already enacted in seven other states, most recently Maine (see Update for Week of May 7th).

Vermont enacted the first-in-the-nation drug price transparency law in 2016, which required the state to identify up to 15 prescription drugs for which the WAC has increased by 50 percent or more over the past five years and 15 percent or more over the past year (see Update for Week of June 20, 2016). California’s subsequent law is considered the most comprehensive in the nation as it requires manufacturers to notify health insurers and government health plans at least 60 days before increases in drug wholesale acquisition costs (WAC) that exceed 16 percent over a two-year period (see Update for Week of November 6th). It applies to drugs with a WAC of \$40 or more.

At least two dozen states have or continue to consider comparable legislation.

Hawaii

Governor considering legislation that would restrict short-term plans, preserve ACA consumer protections

The legislature sent Governor David Ige (D) two bills before the close of the legislative session this month that seeks to protect Hawaii consumers from federal efforts to dismantle the Affordable Care Act (ACA).

S.B. 2340 would codify three of the most popular ACA consumer protections into state law. This includes the provisions allowing young adults to remain on their parents' group plans until age 26, the prohibitions on increasing premiums based on gender or health status, and the requirement that insurers offer coverage to everyone regardless of pre-existing conditions.

H.B. 1520 would bar any short-term health plans from extending coverage beyond the 90-day limit set by the Obama Administration (see Update for the Week of June 20, 2016), even if Trump Administration regulations to extend that limit by up to 364 days are finalized (see Update for Week of February 26th). In addition, it would prevent any insurers from selling or renewing short-term coverage to any consumer who was eligible to purchase coverage through the ACA Marketplace during the previous calendar year (either through open or special enrollment periods). Because most Hawaiians are eligible for Marketplace coverage if they are legal residents, not on Medicare, and not incarcerated, this provision would severely restrict the market for short-term coverage.

Governor Ige has not indicated his position on either bill and has until July 10th to either sign or veto them.

Hawaii was one of ten Democratically-controlled states that considered legislation to stabilize health insurance premiums by creating a reinsurance program that compensated insurers for exceptional claims (see Update for Week of May 7th). However, legislation that would have authorized state agencies to seek the required federal waiver (H.B. 2146/S.B. 2199) failed to advance.

The House Finance Committee also failed to advance S.B. 2924, which would have created a state alternative to the individual mandate under the ACA, even though the measure passed the Senate with only one dissenting vote. New Jersey and Vermont become the first two states to enact such legislation this week (see below).

New Jersey

Governor signs bills creating individual mandate that would fund reinsurance program for insurers

Governor Phil Murphy (D) signed two bills this week that are expected to stabilize health insurance premiums in the individual market by extending the individual mandate under the Affordable Care Act (ACA) and compensating insurers for exceptional claims.

By signing A.3380, Governor Murphy made New Jersey the first state to create its own alternative to the ACA's individual mandate, for which the tax penalties have been repealed starting with the 2019 plan year (see Update for Week of December 18th). (Massachusetts already has an individual mandate that pre-dates the ACA and imposes harsher tax penalties). Vermont Governor Phil Scott (R) also signed legislation this week that will also require residents to purchase minimum essential coverage they can afford or pay a tax penalty, starting in 2020 (see Update for Week of May 7th). However, that bill (H.696) creates a working group charged with creating a different version of the ACA mandate, while New Jersey has decided to simply extend the penalties set by the ACA.

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). However, similar measures have already stalled or failed in Colorado, Connecticut (see Update for Week of March 19th), Hawaii, and Maryland (see Update for Week of May 7th).

The second bill signed by Governor Murphy (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.

Funding for the reinsurance payments would come from revenue collected under New Jersey's individual mandate penalties (A.3380).

If the legislature had not taken action to stabilize the individual marketplace, an analysis completed earlier this year 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).

New York

Insurers blame ACA individual mandate repeal for doubling average 2019 rate hikes

Early rate filings released by the Department of Financial Services (DFS) this week show that 14 health insurers are seeking to hike premiums next year in the individual market by an average of 24 percent.

The average rate hike is skewed by outliers such as Fidelis (serving central New York), which proposed an increase of 38.6 percent. Other insurers are seeking only single-digit increases such as Excellus BlueCross Blue Shield (8.9 percent), MVP Health Plan (6.5 percent), and Capital District Physician Health Plans (5.1 percent).

According to DFS, the Congressional repeal of the tax penalty for the Affordable Care Act (ACA) individual mandate was largest single justification for the rate hikes. Without the repeal, proposed premium increases for 2019 would have averaged only 12.1 percent.

DFS has until August 2nd to reject, modify, or approved the proposed 2019 rates.

Ohio

CMS rejects Insurance Department's application to opt-out of defunct ACA individual mandate

The Centers for Medicare and Medicaid Services (CMS) has rejected Ohio's request for a waiver from the individual mandate under the Affordable Care Act (ACA).

The Department of Insurance was required to submit the request pursuant to legislation passed in 2015 by the Republican-controlled legislature. However, Congress subsequently repealed the tax penalty for the individual mandate starting with the 2019 plan year (see Update for Week of December 18th), making the application largely symbolic.

State regulators insisted that their request was still required, given that the individual mandate itself remains law. However, CMS determined that Ohio's application was "incomplete" as it failed to provide the required information for a Section 1332 State Innovation Waiver under the ACA. For example, the Department failed to identify an alternative plan to would provide coverage that is at least as comprehensive and affordable, nor did it state a reason why the state should be fully-exempted from the ACA requirement that everyone purchase minimum essential coverage they could afford.

Vermont

Governor signs bill creating wholesaler program to import lower-cost prescription drugs

Governor Phil Scott (R) signed S. 175 into law last week, making Vermont the first state to create a wholesaler program to import lower-cost prescription drugs from Canada.

According to Senator Claire Ayer (D), one of the bill's cosponsors, the intent of the program is to target "drugs that have the biggest financial impact". Unlike bills that have been repeatedly introduced in Congress, S.175 compiles a list of the 10-15 most expensive medicines purchased by Vermont residents and then creates a program to purchase those

drugs from Canada at substantially lower cost through authorized wholesalers via an existing supply chain that includes local pharmacies (see Update for Week of February 26th). Details will be formulated by the Agency for Human Services (in consultation with stakeholders and the federal government) and submitted for legislative approval by January 2019.

Several steps remain before the program can become reality. Not only does a funding mechanism still need to be created, the measure requires the state to submit a certification request to the federal government by July 2019. However, it remains very unclear whether the Trump Administration would approve the request since drug importation remains prohibited by federal law. Although President Trump supported drug importation as a candidate, he omitted it from his drug pricing “blueprint” earlier this month while his new Secretary for the Department of Health and Human Services (HHS) criticized it has a “gimmick” (see Update for Week of May 7th).

Drug importation measures have stalled or failed this year in most of the eight states considering them this year, including Colorado, Louisiana, New York, Utah, West Virginia, and Wyoming (see Update for Week of February 26th).

Virginia

Governor to sign Medicaid expansion compromise that finally passes both chambers

After a four-year battle, the House and Senate have approved a budget bill that includes provisions that would make Virginia the 33rd state (along with the District of Columbia) to expand Medicaid under the Affordable Care Act (ACA).

Medicaid expansion had been an extremely polarizing issue in the General Assembly that caused a government shutdown in 2014 when conservative lawmakers flatly rejected any of the expansion alternatives sought by Democrats or moderate Republicans (see Update for Week of September 15, 2014). Subsequent expansion initiatives went nowhere until only a coin flip prevented the Assembly from shifting from a Republican supermajority to Democratic control, giving Medicaid expansion proponents the momentum needed to break the impasse (see Update for Week of January 22nd). Although the House of Delegates passed a Medicaid expansion budget earlier this year, it took a special session for the Senate to come on board (see Update for Week of February 12th).

With only a one-seat majority in each chamber, four Senate Republicans (and 20 Republican Delegates) ultimately agreed to support a compromise bill with Democrats so long as it imposed work requirements for newly-eligible adults and first-time premiums for those earning at least 100 percent of the federal poverty level (FPL). Although each would require a federal waiver, the Trump Administration has already approved comparable provisions in for other Medicaid expansion states, most recently in New Hampshire (see Update for Week of May 7th).

Governor Ralph Northam (D) backed the compromise and is expected to shortly sign the legislation, despite his opposition to the work requirements—the details of which have to be finalized. It is expected to expand coverage after the July 1st start of the fiscal year to roughly 400,000 Virginians earning up to 138 percent of FPL, with the state share of the costs funded through a hospital assessment.

Governor vetoes “counterproductive” Republican bills to undermine health insurance market

Governor Ralph Northam (D) vetoed four Republican-backed bills last week that he insists would “fragment” Virginia’s Affordable Care Act (ACA) Marketplace risk pool, leading to rapidly increasing premiums.”

The first two bills (S.B. 934 and S.B. 935) sponsored by Senator Siobhan Dunnavant (R) would have allowed the creation of non-profit “benefits consortiums”, consistent with proposed regulations by the Trump Administration that would let trade associations band together to offer limited-benefit low-premium plans to do not comply with ACA consumer protections (see Update for Week of January 8th). A third that she co-sponsored with Senator Bryce Reeves (R) (S.B. 844) would follow upon the Trump Administration’s proposal to undo Obama Administration protection against non-ACA complaint short-term health plans that offer coverage for up to 364 days (see Update for Week of February 26th).



Governor Northam concluded that these “skimpy” and “stopgap” plans would siphon consumers with minimal health care needs away from comprehensive ACA Marketplace plans, effectively relegating the Marketplace to a high-risk pool for those with costlier conditions and increasing average premiums by more than 19 percent. For similar reasons, he also vetoed legislation sponsored by Senator Glen Sturtevant (R) (S.B. 964) that would remove the 30-year maximum age limit on low-cost but high-deductible catastrophic plans created by the ACA, even though the bill had unanimously cleared the Senate (see Update for Week of February 12th).

The Governor had proposed amendments to the bills that would prevent them from circumvent key ACA consumer protections like essential health benefits and prohibitions on discriminatory premiums based on gender or health status. The amendments also would have created a working group to study various options for stabilizing the ACA marketplaces. However, these were all rejected by the Senate, which remains narrowly under Republican control.