

Health Reform Update – Week of June 11, 2018

CONGRESS

Trustees warn that repealing the ACA individual mandate sped up Medicare's insolvency by three years

Annual reports released last week by the Medicare Board of Trustees (which includes three members of the President's Cabinet) revealed that Medicare's trust fund will be depleted three years earlier than previously projected due largely to Congress' repeal of the Affordable Care Act (ACA) tax penalty assessed on those who fail to purchase minimum health insurance coverage they can afford (see Update for Week of December 18th).

Last year's report had predicted that Medicare would remain solvent until 2029. However, it concluded that repealing this individual mandate would not only increase the number of uninsured individuals but cause Medicare to make significantly higher payments to hospitals and Medicare Advantage plans. The trustees also noted that the new tax reform law lowered both payroll taxes and revenue from taxing Social Security, which likewise contributed to their conclusion that the trust fund would become insolvent by 2026, when it will only be able to pay 91 percent of hospital-related expenses under Medicare.

In a companion report, the trustees found that Social Security Trust Funds for old-age benefits and disability insurance would still be depleted by 2034, the same year projected in last year's report. It also projects that the cost-of-living adjustment for Social Security benefits will increase from 2.0 to 2.4 percent for next year.

Medicare and Social Security currently account for 40 percent of all federal spending. Medicare now spends an average of about \$13,600 per year per enrollee, which is expected to climb to \$17,000 by 2023.

FEDERAL AGENCIES

Trump Administration will not defend challenge to ACA individual mandate or guaranteed issue requirement

The Department of Justice (DOJ) filed a brief this week in the U.S. District Court for the Northern District of Texas refusing to defend a multi-state lawsuit challenging the constitutionality of key provisions the Affordable Care Act (ACA).

The latest ACA challenge was filed by 20 Republican state attorneys general and opposed by 15 Democratic attorneys general (see Update for Week of February 26th). DOJ lawyers were expected to defend against the lawsuit, as the agency traditionally does for established federal laws. However, in an unprecedented move that cause three DOJ lawyers to withdraw from the case in protest, Attorney General Jeff Sessions (R) argued that because provisions of the law were unconstitutional it could not be defended by the Trump Administration.

The U.S. Supreme Court had upheld the constitutionality of the ACA's individual mandate back in 2012, when Chief Justice Roberts ruled that requiring everyone to purchase minimum essential coverage they could afford or pay a tax penalty was a valid exercise of Congress' power to tax (see Update for Week of June 25, 2012). However, because Congress has zeroed out the tax penalty starting in 2019 (see Update for Week of December 18th), the DOJ is agreeing with plaintiffs' argument that the mandate is no longer constitutional under the Supreme Court decision because there is no longer a tax penalty to be applied.

The DOJ also argued that since the individual mandate is no longer constitutional, the court must also strike down ACA provisions requiring insurers offer coverage to everyone and not vary premiums by health status, since the Obama Administration argued before the Supreme Court that those provisions were "inseparable" from the individual mandate. However, DOJ did not concur with the plaintiff's request that the entire ACA be declared unconstitutional.

The Protect Our Care advocacy campaign immediately declared the DOJ brief to be “the most dangerous sabotage effort yet” from the Trump Administration while California Attorney General Xavier Becerra (D) and the Kaiser Family Foundation warned of that the uncertainty the brief would create among insurers currently filing proposed rates for 2019 would only lead to further premium spikes in the individual market (see Update for Week of May 28th). A broad coalition of insurers, provider groups, and consumer advocates immediately filed 11 friend-of-the-court briefs opposing the DOJ’s position and arguing in favor of maintaining the prohibition of pre-existing condition discrimination.

Although it is extremely rare for the DOJ not to defend existing federal laws, the Attorney General noted that the DOJ under the Obama Administration had declined to defend the constitutionality of the Defense of Marriage Act.

The Administration’s position drew a swift rebuke from Senate leaders with Lamar Alexander (R-TN), chair of the Senate’s health committee, declaring that “the Justice Department argument in the Texas case is as far-fetched as any I’ve ever heard” and that “he didn’t hear a single senator say that they also thought they were repealing protections for people with pre-existing conditions” when the individual mandate penalties were repealed. Majority Leader Mitch McConnell (R-KY) similarly insisted that “everybody I know in the Senate — everybody — is in favor of maintaining coverage for preexisting conditions.”

However, key Republicans such as Senator Ted Cruz (R-TX) and Florida Governor Rick Scott (R-FL), a Senate candidate, came out in favor of the DOJ position that pre-existing conditions should not be protected.

Appeals court rejects insurer arguments that they are owed outstanding ACA risk corridor payments

A three-judge panel for the U.S. Court of Appeals for the Federal Circuit sided with the Centers for Medicare and Medicaid Services (CMS) this week in the ongoing dispute over whether insurers are owed roughly \$8.3 billion in outstanding risk corridors payments under the Affordable Care Act (ACA).

The risk corridor fund was one of three temporary risk mitigation programs created by ACA. They were meant to stabilize insurance markets during the initial three years of full ACA implementation by compensating insurers that incurred an extraordinary number of high-cost claims.

Unlike the reinsurance fund where collections largely aligned with expectations (see Update for Weeks of February 8 and 15, 2016), the risk corridors program had a \$2.5 billion initial shortfall forcing insurers to receive only 12.6 percent of the payments they were due for 2014 (see Update for Week of September 28, 2016). As a result, CMS used all 2015 collections to pay outstanding amounts owed to insurers for 2014.

Republican lawmakers led by Senator Marco Rubio (R) insisted the reinsurance and risk corridor payments amount to an “insurer bailout” and inserted an “appropriations rider” into a 2015 bipartisan spending bill that prohibited CMS from making risk corridor payments in excess of collections (see Update for Week of December 15, 2014). That provision was at the center for the Federal Circuit’s decision, which concluded Congress’ “intent to temporarily cap payments out at the amount of payments in was clear from the appropriations riders and their legislative history,” regardless of the intent of a Democratically-controlled Congress at the time the ACA risk corridor payments were enacted. The Court held that “we simply cannot infer that...upon enacting the appropriations riders, Congress intended to preserve insurers’ statutory entitlement to full risk corridors payments.”

The three-judge panel also cited 2013 regulations promulgated by CMS stating that “the risk corridors program is not required to be budget neutral.” Since this was issued before the Marketplaces opened in 2014, the court found that it “constituted the final word” on whether CMS was obligated to make payments in excess of collections.

The ruling from the appellate court overturns a decision in favor of Moda Health, in which the U.S. Court of Federal Claims ordered CMS to pay the insurer the full \$214 million in risk corridors payments that it was owed under the ACA (see Update for Week of February 27, 2017). It also upholds an earlier contrary decision from the same court to

dismiss a lawsuit brought by Land of Lincoln seeking their \$73 million in unpaid risk corridor funding (see Update for Week of December 5, 2016).

Although both plaintiffs could appeal to the U.S. Supreme Court, for the time being the appellate court decision is likely to block risk corridors lawsuits filed by at least 20 other insurers. Four are the only of the 23 Consumer Operated and Oriented Plans (CO-OPs) created with ACA loans that have survived despite the shortfall in risk-corridor funding (see Update for Week of November 30, 2015). Others are insurers that insist they were forced to exit the ACA Marketplaces in 2017 as a result of the shortfall (see Update for Week of August 15, 2016).

All of the judges at the appellate and lower court were appointed by Republican presidents.

HHS will allow insurers to “silver-load” premiums for 2019 but likely not for 2020

Health and Human Services Secretary Alex Azar announced last week that insurers will be allowed to mitigate the loss of cost-sharing reductions under the Affordable Care Act (ACA) by hiking premiums only for the silver-tier plans to which they were tied, but that the practice may likely be prohibited starting with plan year 2020.

All but nine states relied on the practice of “silver-loading” to prevent insurers from taking massive losses after President Trump eliminated CSR payments to insurers, even though insurers were still legally required to reduce cost-sharing for those earning 100-250 percent of the federal poverty level and enrolling in silver-tier coverage (See Update for Week of November 13th). However, the Congressional Budget Office (CBO) found that “silver-loading” caused the federal government to pay \$10 billion more in premium tax credits than anticipated (a 21 percent increase), since the amount of the credit was tied to the second lowest-cost silver plan (see Update for Week of April 16th). If allowed to continue, the federal government would have to pay up to \$44 billion more in premium tax credits over the next ten years.

As a result, the Secretary told Congress that the agency was considering barring “silver-loading” but would not be able to promulgate the needed regulations before insurers starting submitting premium requests last month for the 2019 open enrollment season. The Administration for the Centers for Medicare and Medicaid Services (CMS) acknowledged earlier this year that 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 by 16 percent from \$106 to \$89 (see Update for Week of April 16th). She also conceded 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.

Colorado and Vermont have already reconsidered their decision not to allow “silver-loading” last year and will let insurers hike only silver-tier premiums to reflect the loss of the CSRs (see Update for Week of March 19th). In Vermont, the decision has already lowered Blue Cross and Blue Shield’s proposed rate hike from an average of 7.5 percent to 5.3 percent, while the only other Marketplace competitor lowered their increase from 10.9 percent to 6.4 percent.

North Dakota, Vermont and the District of Columbia were the only three states that specifically prohibited the practice of “silver-loading” last year. The latter two did not allow offsetting premium increases because they previously were the only two jurisdictions that required Marketplace and non-Marketplace plans to be identical for the individual market. However, after Vermont insurers lost \$12 million due to the loss of CSRs, the state enacted a new law allowing differential pricing in and out of the Marketplace. As a result, insurers within Vermont Health Connect (the ACA Marketplace) can add the cost of lost CSRs to silver plans for 2019, while silver plans outside the Marketplace will not have the lost CSR costs reflected (See Update for Week of March 19th).

Despite the change in Vermont, District of Columbia regulators announced that they will continue to require that insurers bear the full loss of the CSR elimination.

Final rule on association health plans to be released imminently following OMB paperwork clearance

The Office of Management and Budget (OMB) completed the required paperwork clearance this week for proposed regulations from the Department of Labor (DOL) that would allow for the sale of limited-benefit association health plans across state lines that need not comply with most consumer protections required by the Affordable Care Act (ACA) (see Update for Week of January 8th).

The clearance allows DOL to release the final regulations as early as next week. OMB held four separate meetings with stakeholders prior to issuing the clearance and recommended undisclosed changes to the rule. However, the final version is expected to still require that the AHPs comply at least with the ACA's mandate that insurers cover everyone and not increase premiums for those with pre-existing conditions.

Stakeholders in support of the rule (such as the National Restaurant Association and other small business groups) are urging DOL to make AHPs exempt from all state regulation, while opponents (such as consumer groups, insurers, state regulators, and ACA Marketplace officials) want to maintain state authority of AHPs, especially to prevent fraudulent or abusive practices that occurred in past experiments with AHPs.

Critics of the DOL rule also point out that several states including Georgia, Maine, and Wyoming have already passed laws allowing interstate association plans and were not able to draw any interest from insurers (see Update for Week of April 9, 2012). Last year's Congressional bill to allow association health plans (H.R. 1101) gained only 37 Republican cosponsors.

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 subsequently 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). Insurers submitting early rate filings for 2019 are predicting a ten percent increase in morbidity for Marketplace risk pools from the combination of association health plans and the limited-benefit short-term plans also proposed by the Trump Administration (see Update for Week of May 7th). America's Health Insurance Plans predicts that both initiatives would increase premiums by an average of 5.7 percent next year (see Update for Week of May 28th).

STATES

HIV/AIDS groups urge states to investigate if copay accumulator programs impede access to high-cost drugs

A coalition of 60 HIV/AIDS advocacy groups sent a letter to all of the nation's state attorneys general and insurance commissioners last month urging them to investigate insurer changes in how they treat copayment assistance programs for costly prescription drugs.

Starting in 2018, several dominant insurers including Blue Cross and Blue Shield, CIGNA, and UnitedHealthcare have started using copay accumulator programs, which refuse to allow copayment assistance from drug manufacturers from counting towards the annual deductible for patients. According to the coalition (called the Federal AIDS Policy Partnership), this practice can dramatically increase consumer out-of-pocket costs by \$4,000 or more per year, leaving low-to-moderate consumers in many cases "with no affordable coverage option".

Insurers have justified the copay accumulator programs by arguing that copayment assistance is being used to "steer" patients toward choosing name brand-name drugs rather than less-costly generic alternatives, with America's Health Insurance Plans referring such assistance as a "gimmick". However, the coalition pointed to research from the

Center for Health Policy and Economics and the University of Southern California, which show that as recently as 2016, over half (51 percent) of drugs with copay assistance had no generic substitute.

The same research showed that 20 percent of prescriptions for brand-name drugs used a copay assistance coupon. Furthermore, among the 200 most costly drugs in 2014, 132 were brand-name drugs and copay coupons were needed to afford 68 percent of these drugs.

Louisiana

Governor signs bills authorizing payments to insurers for exceptional claims

Governor John Bel Edwards (D) signed two bills last week that seek to make Louisiana the fourth state with a federally-approved reinsurance program to mitigate premium spikes in the individual market.

H.B.246 authorizes the state to seek the required Section 1332 State Innovation Waiver under the Affordable Care Act (ACA) to implement the reinsurance program that would compensate insurers for exceptional claims, comparable to the ACA reinsurance program that expired after 2016. The second measure (H.B.472) creates the Louisiana Health Reinsurance Association to oversee the program and authorizes the state to levy a fee of not more than \$2.50 per member per month on Louisiana insurers (in both the individual and group markets) in order to fund the state share of costs.

Individual market premiums in Louisiana increased by only a 21 percent average for 2018, well below the 34 percent nationwide average for states with federally-facilitated Marketplaces (like Louisiana). However, rate hikes are expected to be only in the single-digits next year if the reinsurance program is approved in time. The commissioner estimates that enrollment would also increase by 7.5 percent as a result of the approval.

The bills had broad bipartisan support, as well as the backing of Insurance Commissioner James Donelon (R), who had already drafted the waiver request and sent it out for public comment last spring. He projects the insurer level will initially be \$1.40 per member per month while the federal government will assume \$100 million of the costs. However, these costs would be offset by the savings the federal government will incur in ACA premium subsidies, due to premiums that the commissioner estimates will be at least 17 percent lower, based on the experience of the three other states with federally-approved reinsurance programs (see Update for Week of December 18th).

Wisconsin's reinsurance waiver request remains pending with the federal Centers for Medicare and Medicaid Services and roughly ten other states including Maine (see below) are planning to submit similar applications this year (see Update for Week of April 16th).

Maine

Lower court orders Governor to comply with voter mandate to expand Medicaid

The Maine Superior Court has ordered Governor Paul LePage (R) to comply with a voter mandate to expand Medicaid to roughly 70,000 Mainers earning from 100-138 percent of the federal poverty level (FPL).

More than 59 percent of Maine voters approved the referendum last fall, making Maine the first state to expand Medicaid through the ballot box (see Update for Week of November 6th). It required state agencies to submit the two-page state plan amendment (SPA) expanding Medicaid to the federal Centers for Medicare and Medicaid Services (CMS) by April 3rd and adopt implementing regulations by July 3rd.

However, the outgoing Governor, who previously vetoed six attempts by the Democratically-controlled legislature to expand Medicaid, steadfastly refused to submit the SPA to CMS unless the legislature appropriated double the \$30.5 million that Manatt Health predicted Maine would need to pay for the ten percent share of Medicaid expansion costs (see Update for Week of December 18th).

Maine Equal Justice Partners and other consumer and providers groups filed suit in the Superior Court after the legislature adjourned without making any appropriation (see Update for Week of May 7th). The court agreed with the plaintiffs' argument that Maine had more than enough budget reserves to fund the expansion through at least May 2019 and could enter into a binding contract with the Trump Administration to expand Medicaid without a specific appropriation. It ordered the Governor to submit the SPA by June 11th, noting that the legislature was free to withdraw from the ACA expansion if it was unable to fund the state-share of costs (set by the ACA at no more than ten percent), pursuant to the U.S. Supreme Court decision that made the ACA expansion optional for states (see Update for Week of June 25, 2012).

Governor LePage (R) immediately asked the Superior Court to stay their order pending his appeal to the Maine Supreme Judicial Court.

Renewed reinsurance program could cut 2019 premium increases in half

The two health plans participating in the Affordable Care Act (ACA) Marketplace submitted rate filings last week that could cut their proposed premium increases for 2019 by up to half if Maine receives federal approval to resume its reinsurance program to compensate insurers for exceptional costs.

Harvard Pilgrim Health Care is seeking an average rate hike of 9.5 percent for Marketplace plans, while Community Health Options (CHO) proposed a 9.2 percent average increase. While these figures are far below the rate hikes sought by Marketplace insurers in other states (see Update for Week of May 7th) and the unprecedented 20-40 percent increases they sought last year (see Update for Weeks of May 29 and June 5, 2017), both insurers submitted separate filings with the Bureau of Insurance that would reduce their average increases as low as 4.6 percent if the reinsurance program that Maine had in place prior to the ACA were restored.

In addition, Anthem Blue Cross pledged that it would return to the Marketplace if the reinsurance program is restarted by January 2019 (although it will increase premiums by an average of 8.7 percent). Anthem had participated through 2017 but abruptly exited last year after President Trump appeared ready to terminate the cost-sharing reductions under the ACA (see Update for Week of October 2, 2017).

Governor Paul LePage (R) signed legislation last year authorizing the state to seek federal permission to resume the reinsurance program, which was part of the state-subsidized Dirigo Health program (providing coverage to small employers and the uninsured) that the Governor had eliminated (see Update for Week of June 20, 2011). The Maine Guaranteed Access Reinsurance Association charged a \$4 per person per month fee on individual and small- and large-group plans and redistributed that revenue to individual plans with exceptional claims. It was discontinued once the temporary reinsurance program under the ACA went into effect in 2014.

The Bureau of Insurance submitted the request for a federal Section 1332 waiver on May 9th and the public comment period runs through July 8th. Bureau officials predicted that restarting the reinsurance program would lower individual market premiums in Maine by nine percent, based on the experience of the three other states (Alaska, Minnesota, and Oregon) with federally-approved reinsurance programs (see Update for Week of December 18th).

Harvard Pilgrim officials said their rate increases were lower than expected because the insurer assumed when President Trump was elected that the individual mandate under the ACA would be repealed and had already adjusted their premiums last year to reflect the sicker and more costly risk pools that would likely result. However, CHO officials blamed half of their 2019 increase on Congress' repeal of individual mandate penalties (see Update for Week of December 18th) and the other half on the Trump Administration's proposal to let insurers offer short-term and association health plans that need not comply with ACA consumer protections (see Update for Week of February 26th).

CHO is one of only four remaining Consumer Operated and Oriented Plans (CO-OP) that were created with ACA loans. It was nearly dissolved in 2016 when a shortfall in the ACA reinsurance and risk corridor program forced most to

close (see Update November 30, 2015) but has survived due to an improvement in its case-mix (see Update for Week of September 18th). CHO continues to serve the largest share of the Marketplace (roughly 39,000 subscribers) while Anthem served 28,000 when it last participated in 2017 and Harvard Pilgrim serves just under 21,000.

Governor LePage is appealing a recent court decision forcing him to immediately move forward with the state's participation in the Medicaid expansion under the ACA (see above). Once implemented, the Bureau expects that Medicaid expansion will reduce the number of individual market consumers by 19 percent. However, the Governor is pursuing drastic cuts in Medicaid enrollment before he leaves office next year by seeking federal waivers that would allow his Administration to impose a work requirement on newly-eligible enrollees, unprecedented premiums for households earning as little as 51 percent of the federal poverty level, and the elimination of retroactive eligibility.

Michigan

Legislature threatens to eliminate Medicaid expansion if CMS does not approve work requirements, premiums

Governor Rick Snyder (R) indicated this week that he would sign legislation that will impose new work requirements for “able-bodied adults” enrolled in the Healthy Michigan Medicaid expansion program and dramatically increase premiums for those in the expansion population.

S.B. 897 passed the House and Senate on a mostly partly line vote and engendered national controversy for initial provisions that would have exempted 17 rural counties from the work requirement, while imposing it only on urban and predominantly African-American counties with highest unemployment rates. The rural exemption was ultimately removed, even though the Trump Administration had approved similar exemptions in Kentucky and other states (see Update for Week of May 7th).

The bill specifically requires “able-bodied” Healthy Michigan adults aged 19-62 to work (or engage in other qualifying activities like job training, school, or substance abuse treatment) for at least 80 hours per month. It also increases premiums for the expansion population (those earning 100-138 percent of the federal poverty level) to up to five percent of annual income.

Both the work requirements and higher premiums require a federal waiver from the Trump Administration. Although the Administration has already approved comparable work requirements in four states, the new premiums would be the highest of any state Medicaid program. Lawmakers sought to force the Administration's approval of the premiums by including a controversial “trigger” provision that would terminate the entire expansion program if they are not approved within 12 months. More than 670,000 people are currently enrolled in Healthy Michigan and would likely become uninsured if the program were terminated.

The bill's primary sponsor, Senator Mike Shirkey (R), acknowledged that the work requirements would likely apply to roughly 350,000 adults in Healthy Michigan, force up to 54,000 to drop out of the program, and cost the state \$17.5 million to administer. The work requirements would go into effect for 2020.

Governor Snyder had made Michigan only the fourth state under Republican control to participate in the ACA expansion when he created Healthy Michigan (see Update for Week of March 31, 2014) and has staunchly opposed efforts by Congressional Republicans to repeal it (see Update for Week of January 9, 2017). The expansion has had the support of several key Republicans because the Governor obtained a federal waiver from the Obama Administration that allowed the program to charge copayments on enrollees that could be reduced through “healthy behaviors” such as smoking cessation, as well as a requirement that enrollees contribute up to two percent of their income to health savings accounts that can be used to pay out-of-pocket medical costs. It was based on the Medicaid expansion alternative that Vice President-elect Mike Pence (R) enacted in Indiana (see Update for Weeks of January 26 and February 2, 2015).

The law creating Healthy Michigan has an automatic termination clause if the state share of costs (that will phase-up to ten percent in 2020 and beyond) exceeds the savings from the program. However, the House Fiscal Agency

reported that due to federal matching funds received under the ACA that will not happen any time before 2022, as the Medicaid expansion has allowed Michigan to save \$235 million per year on spending for other health-related programs, such as prisoner health care (see Update for Week of January 9, 2017).

New Mexico

Marketplace to add fifth competitor for 2018

The largest health care provider in New Mexico announced this week that it will return to the Affordable Care Act (ACA) Marketplace for 2019, giving consumers five insurers from which to choose.

Presbyterian Healthcare Services submitted proposed rates this week for coverage to be offered by Presbyterian Health Plan, which had participated in the Marketplace for individual consumers until the temporary reinsurance program under the ACA expired after 2016. It has continued to participate in the small group Marketplace.

Presbyterian joins three other health insurers that have already decided to enter or return to the ACA Marketplaces next year (startup Bright Health in Arizona and Tennessee, Ambetter in North Carolina, and Anthem Blue Cross Blue Shield in Maine [see above]).

The Marketplace's largest insurer, Molina, had threatened to leave the Marketplace at the end of 2018 due to Superintendent's decision not to renew its Medicaid managed care contract—the largest part of Molina's business in New Mexico. However, their decision to file proposed 2019 rates this week suggests that no final decision has been made.

Premium increases sought by the five insurers are far less dramatic than last year when Molina received a 56 percent average increase, followed by Christus at 49 percent, New Mexico Health Connections (NMHC) at 28 percent, and Blue Cross and Blue Shield (BCBS) at 26 percent. In sharp contrast, Molina (which leads all Marketplace insurers with more than 25,000 subscribers) is seeking an average decrease next year of 0.4 percent. NMHC sought only half of last year's increase (14 percent) for its 18,000 subscribers, Christus proposed a nearly 15 percent increase for 2,300 subscribers, and BCBS sought a 9.2 percent increase for roughly 3,500 subscribers. The highest average rate hike of 18.5 percent was proposed by the new entrant Presbyterian Health Plan.

NMHC is one of only four Consumer Operated and Oriented Plans (CO-OPs) created with ACA loans that have survived despite the loss of ACA reinsurance and risk corridor funding (see Update for Week of November 30, 2015), thanks to its sale last year to Virginia-based Evolent Health.

Roughly 50,000 consumers currently receive coverage through the Marketplace (known as beWellnm), although the Superintendent estimates that up to 250,000 New Mexicans could potentially be eligible.

North Carolina

House rejects bill that would have allowed non-profit health plans to be exempt from ACA standards

The House voted 53-38 this week to block Senate-passed legislation that sought to allow for the sale of limited-benefit health plans that were exempt from nearly all consumer protections under the Affordable Care Act (ACA).

The Senate amended an unrelated bill (H. 933) to include the provision, which would have allowed non-profit organizations that have existed for at least ten years and which offer membership in all 100 counties to offer their members health plans that would be exempt from many state and federal regulations. This specifically included consumer protections mandated by the ACA, such as essential health benefits, and requirements that insurers offer coverage to everyone without higher premiums for those with pre-existing conditions.

The amendment was designed to let the North Carolina Farm Bureau offer stripped-down plans to its members and far less cost than ACA-compliant coverage. It was modeled on the exempt plans offered by the Tennessee Farm

Bureau for over two decades and recently enacted for the Iowa Farm Bureau (see Update for Week of April 16th). However, critics (including some of the state's dominant insurers) pointed out that Farm Bureau plans in Tennessee have increased individual market premiums in that state for those remaining in compliant plans. Because the provision in H.933 was not limited just to Farm Bureau plans but could apply to any non-profit, Republican House leaders like Rep. Donny Lambeth (R), co-chair of the Health Committee, agreed to requests from the Department of Insurance that the bill should be held for further study.

The Trump Administration is expected to shortly finalize regulations that would allow for the same of similar association health plans nationwide (see above). However, those regulations initially required that such plans still comply with ACA requirements to offer coverage to everyone without varying premiums based on health status (see Update for Week of January 8th).

Pennsylvania

Insurers seeking only five percent average rate hike for 2019 after new regulations mitigated increases

Insurance Commissioner Jessica Altman (D) announced last week that premium increases have moderated dramatically since 2018 as insurers are only proposing a five percent average rate hike for individual market consumers.

Pennsylvania saw some of the highest premium increases in the nation for 2018, with the commissioner approving a 30.6 percent average increase in individual plan premiums following the Trump Administration's elimination of Affordable Care Act (ACA) cost-sharing reductions only days before the start of the annual open enrollment period (see Update for Week of November 6th).

Commissioner Altman credited actions by Governor Tom Wolf (D) for avoiding the 2019 premium spikes that consumers will experience in neighboring Maryland, where the dominant carrier is trying to hike rates by up to 91 percent following Congress' repeal of the ACA's individual mandate and Trump Administration's proposal to allow "junk" plans (see Update for Week of May 7th). The five percent average increase is far below the 19 percent hike projected for Pennsylvania by the Urban Institute and due in large part to increased competition, as the number of Marketplace insurers will be higher next year for 31 of the state's 67 counties while the number of counties with only one participating insurer will fall from 20 to only eight.

Pennsylvania is one of 38 states defaulting to the federally-facilitated Marketplace (FFM) and thus had its open enrollment period cut in half last year while its marketing and outreach budget was slashed by 90 percent by Trump Administration (see Update for Week of November 13th). However, it was largely able to maintain its same enrollment numbers as 2017 thanks largely to the Governor's increase in the state budget for marketing and outreach, which enabled major insurers like Independence Blue Cross to actually sign-up ten percent more Marketplace consumers.

Rhode Island

Market Stability Workgroup recommends individual mandate, reinsurance, and limits on short-term plans

A Market Stability Workgroup was convened by the Office of the Health Insurance Commissioner (OHIC) and HealthSourceRI (HSRI) recommended this week that Rhode Island followed the lead of other states and implement a state alternative to the individual mandate under the Affordable Care Act (ACA) "as soon as is practicable".

Both New Jersey and Vermont have already enacted legislation creating their own individual mandates (see Update for Week of May 28th), following Congress' repeal of the tax penalty for the ACA's version starting in 2019 (see Update for Week of December 18th). Massachusetts has their own individual mandate that pre-dated the ACA.

The Workgroup recommended that the legislature followed the "federal structure" of the ACA's individual mandated (as did New Jersey). It notes that the revenue from the tax penalties (estimated at \$9.7 million as recently as 2016) could be used to fund a reinsurance program to compensate insurers for exceptional claims, similar to the



reinsurance payments under the ACA that expired after 2016. Their report urged the legislature to authorize state agencies to submit the required Section 1332 State Innovation Waiver under the ACA, which three other states (Alaska, Minnesota, and Oregon) have already used create federally-approved reinsurance programs that have successfully mitigated premium increases (see Update for Week of November 13th).

In addition to creating a reinsurance program by 2020, the Workgroup strongly recommended that the legislature act this year to limit the use of short-term health plans. Proposed rules from the Trump Administration would allow insurers to offer limited-benefit coverage that circumvents most ACA consumer protections as long as they expire within 364 days (see Update for Week of February 26th). The report does not state whether Rhode Island should apply the same 90-day limit put in place by the Obama Administration and sought by several other states (see Update for Week of May 28th). However, it does urge the legislature to give OHIC the regulatory authority to ensure that short-term plans must comply with the same consumer protections required for other private insurance coverage offered in Rhode Island.

The legislature is already considering pending bills to create a reinsurance program (S.2934) and provide protections from short-term plans (S.2931). Both passed the Senate this week. Because Rhode Island already prohibits short-term plans from denying coverage based on pre-existing conditions, none are currently offered in the state. However, S.2931 would prevent short-term plans without this protection from becoming available once the Trump Administration regulations are finalized.

The Workgroup was chaired by representatives of Blue Cross and Blue Shield and the Health Insurance Advisory Council. Participants included state lawmakers, regulators, physicians, hospital associations, and consumer groups.

Separate from the Workgroup, Governor Gina Raimondo (D) announced this week that HealthSourceRI has agreed to partner with CVS Health to let consumers of the ACA Marketplace pay their monthly premiums at any of 9,300 CVS pharmacy locations nationwide. HealthSourceRI customers previously could only pay with checks money orders, or electronic transfers through the mail, online, or at a HealthSourceRI center. However, any of the CVS pharmacies will now accept credit cards, debit cards, or cash as premium payment.

Washington

Marketplace insurers seek 19 percent average rate hike for next year

Insurance Commissioner Mike Kreidler (D) announced this week that 11 health insurers have submitted filings to offer 74 plans in the individual market for 2019, with a 19 percent average premium increase.

Final rates will have to be approved by the commissioner before plans can be certified on September 13th for sale on the state-based Marketplace that Washington created pursuant to the Affordable Care Act (ACA). The highest increase in the Marketplace (called the Washington Healthplanfinder) will likely be borne by subscribers for Kaiser Foundation Health Plan of Washington (seeking a nearly 30 percent average rate hike), while those enrolled in Premera BlueCross, Regence BlueCross BlueShield of Oregon, or Regence Blue Shield will see increases of only about 2.5 percent to 7.5 percent. The lowest average rate hike belongs to BridgeSpan Company at only 0.89 percent.

There will be no bare counties for 2019, an improvement from last year when two counties were left without any Marketplace insurers following initial rate filings, before the commissioner successfully persuaded BridgeSpan, Molina, and Premera to expand their coverage areas (see Update for Week of July 10th). However, Marketplace consumers in 14 counties will still have only one insurer from which to choose.