

## Health Reform Update – Week of August 27, 2018

### CONGRESS

#### ***Senate Democrats try to force vote on bill to overturn regulations allowing short-term health plans***

Senator Tammy Baldwin (D-WI) introduced a resolution this week seeking to overturn recent Department of Health and Human Services (HHS) regulations that dramatically loosen restrictions on short-term health plans that do not comply with the Affordable Care Act (ACA).

The resolution (S.J.Res. 63) would invoke the *Congressional Review Act (CRA)*, which gives Congress the authority to reverse new federal regulations. The effort is not likely to succeed, as the House would have to pass the same resolution with either the President's signature or a veto-proof majority.

However, Senator Baldwin acknowledged that the resolution is largely intended to at least force Senators to vote on a measure that would harm voters with pre-existing conditions prior to the midterm elections. At least 30 Senate Democrats have already cosponsored the resolution, meeting the CRA threshold to require that a vote be held.

The Obama Administration had limited short-term health plans to no more than 90 days (see Update for Week of June 20, 2016). However, the HHS rule expanded that limit to 364 days and allowed plans to be renewed for up to three years (see Update for Week of August 13<sup>th</sup>).

Studies from the Urban Institute and the Centers for Medicare and Medicaid Services (CMS) own chief actuary predicted that the HHS rule would cause up to 4.2 million consumers to be shifted from ACA-compliant coverage into short-term coverage (see Update for Week of May 28<sup>th</sup>). Because these would largely be healthier and less-costly consumers, the studies warned that persons with pre-existing conditions would face dramatically higher premiums as they would be left in risk pools skewed towards costlier consumers.

Senator Baldwin insisted that the short-term health plan rule was the "latest act of sabotage" by the Trump Administration that will "increase cost and reduce access to quality coverage for millions" by expanding the availability of "junk" health plans that provide very limited benefits. Several mostly Democratically-controlled states have already taken action to protect against the expansion of short-term health plans (see below).

#### ***Congress and White House coordinate efforts to require price disclosure in prescription drug ads***

The White House Office of Management and Budget (OMB) is reviewing proposed regulations from the Department of Health and Human Services (HHS) that members of Congress acknowledge are connected to their effort to require advertisements for prescription drugs to disclose pricing information.

Senators Chuck Grassley (R-IA) and Dick Durbin (D-IL) confirmed that the bipartisan amendment they successfully attached this week to an HHS appropriations bill would provide at least \$1 million in funding needed to support regulations that bring "price transparency to prescription drug advertising." The proposal was part of the drug pricing "blueprint" released earlier this year by the Trump Administration (see Update for Week of May 7<sup>th</sup>). However, the pharmaceutical industry has pushed back on disclosing prices in advertising and questioned whether HHS even has the legal authority to impose such a requirement.

It is not clear if the measure will also pass the House, which has yet to consider a counterpart HHS appropriations bill. However, the proposed rule is expected to be released by OMB within the next 30 days.

### ***Congress urges HRSA to use existing authority to heighten 340B oversight***

A bipartisan letter from the leaders of the House Energy and Commerce and Senate Health, Education, Labor and Pensions (HELP) committees called last week for the Trump Administration to promptly issue regulations that clarify three specific areas for the Section 340B Drug Pricing program.

The director for the Health Resources and Services Administration (HRSA), which has jurisdiction over 340B, had urged Congress to expand the agency's regulatory authority in response to findings from the Government Accountability Office, Health and Human Services Inspector General, and Energy and Commerce Committee that HRSA was not conducting the oversight needed to ensure participating 340B hospitals were not passing savings from discounted drugs onto consumers and instead reaping "windfall" profits (see Update for Week of July 9<sup>th</sup>). However, the lawmakers insist in their letter that HRSA already has the existing authority to

- (1) establish a binding Administrative Dispute Resolution (ADR) process to resolve disputes over compliance with 340B program requirements;
- (2) authorize the imposition of civil monetary penalties (CMPs) against manufacturers that "knowingly and intentionally overcharge a covered entity for a 340B drug"; and
- (3) issue "precisely defined" standards for calculating 340B ceiling prices.

Both committees held several hearings this summer on ways that Congress could heighten reporting and transparency requirements for 340B providers and otherwise increase HRSA oversight, leading to a flurry of at least 15 House and Senate bills (see Update for Week of July 9<sup>th</sup>). However, HELP committee chair Lamar Alexander (R-TN) acknowledged that none are likely to be passed during an election year.

## **FEDERAL AGENCIES**

### ***GAO confirms that Trump Administration policies depressed ACA Marketplace enrollment for 2018***

The nonpartisan Government Accountability Office (GAO) issued a new report last week criticizing the Trump Administration for depressing enrollment in the Affordable Care Act (ACA) Marketplaces.

The watchdog specifically blamed the Department of Health and Human Services (HHS) for slashing funding for marketing and outreach by 90 percent (including a 40 percent to the navigator program) shortly before the start of the 2018 open enrollment period (see Update for Week of November 6<sup>th</sup>). It directly attributed the five percent decrease in enrollment for the federally-facilitated Marketplaces (see Update for Week of February 12<sup>th</sup>) on the Administration's dramatic funding cut and found the data that HHS used to justify the cut to be "problematic" and "unreliable".

The GAO report also criticized HHS for ending the Obama Administration's practice of setting annual enrollment targets and urged the agency to resume the targets in coming years. However, HHS officials responded that "it does not believe that enrollment targets are relevant to assess the performance of a successful open enrollment period" and declined to accept the recommendation.

Democratic lawmakers seized upon GAO's conclusion as evidence that the Administration was actively trying to "sabotage" the ACA Marketplaces, citing its decision to also abruptly eliminate ACA cost-sharing reductions (see Update for Week of November 6<sup>th</sup>), repeal the tax penalties for the individual mandate (see Update for Week of December 18<sup>th</sup>), and allow healthier and lower-cost consumers to enroll in cheaper limited-benefit plans (see Update for Week of February 26<sup>th</sup>). In particular, they noted that GAO found the budget from television advertising (the most effective form of Marketplace promotion) went from \$26.6 million under the Obama Administration to zero under the Trump Administration.

However, Trump Administration officials pointed out that the GAO report did credit HHS for taking actions to improve the [www.healthcare.gov](http://www.healthcare.gov) web portal and reduce call center wait times.

***Drugmakers, consumer groups protest CMS use of indication-based drug formularies for Medicare Part D***

. The Centers for Medicare and Medicaid Services (CMS) issued a memo this week announcing that it will give Medicare Part D plans the flexibility to add or exclude formulary drugs based on a particular medical indication.

The memo from Administration Seema Verma promoted the use of the “indication-based formulary design” as a tool that will give Part D plans “additional negotiating leverage” to lower drug prices (especially for “high-cost drugs”), since they will be able to “cover the best drug for each patient condition.” She insisted the change (effective January 1, 2020) would increase the number of drugs available to enrollees and diversify plan formularies. However, the memo noted that Part D plans must still ensure there is a “therapeutically similar medication for non-formulary indications.”

Drug manufacturers, consumer groups, and Pew Charitable Trusts opposed the policy change when it was included as part of the drug pricing “blueprint” released earlier this year by the President, insisting that it will limit patient access and increase prices for higher-cost drugs (see Update for Week of May 7<sup>th</sup>). However, indication-based formulary designs are backed by the top three Part D plan sponsors (United HealthCare, CVS Health and Humana) even though Humana acknowledged it could lead to higher prices for high-value indications.

Under current policy, Part D plans must cover every FDA-approved indication for each drug in their formulary. However, supporters of the change note that private insurers are frequently allowed to exclude drugs for specific indications from their formularies. CVS Health insists that “net savings have resulted” from using “indication-based pricing” for their commercial plan subscribers and urged CMS to allow them to “offer this in Medicare and Medicaid”.

***CMS awards ACA Marketplaces \$8.6 million in leftover rate review funds***

The Centers for Medicare and Medicaid Services (CMS) announced this week that it will award \$8.6 million to 30 states to support efforts to reform the Marketplaces created pursuant to the Affordable Care Act (ACA).

CMS using unspent funds from the \$250 million the ACA allocated to enhance state rate review authority. Agency officials explained that the surplus resulted from states either not requesting the rate review funds or returning unused amounts after rate review projects came in under budget.

Grant applications already suggest that states are likely to use the \$8.6 million in leftover funding to implement reforms related to essential health benefits or guaranteed availability/renewability of coverage. The grants will be good for 24 months from the award date.

***SSA adds five more conditions to compassionate allowance program***

The acting commissioner for the Social Security Administration (SSA) announced last week that the agency has added five new diagnoses to the list of medical conditions that receive expedited review for federal disability benefits.

A total of 233 conditions are now included in the Compassionate Allowance program, which started in 2008 with only 50 diagnoses but expands each year based upon input from the National Organization for Rare Disorders and other patient advocates and medical experts (see Update for Week of December 3, 2012).

The fast-track review has enabled over 500,000 applicants to receive a decision within 10-15 days, instead of months or years. However, it does not expedite the 24-month Medicare waiting period once applicants qualify for Social Security Disability (SSD) benefits.

The newly-added conditions are fibrolamellar cancer, megacystis microcolon, intestinal hypoperistalsis syndrome, megalencephaly capillary malformation syndrome, superficial siderosis of the central nervous system, and tetrasomy 18p.

## STATES

### California

#### ***Protections against “junk” insurance headline flurry of health reform bills sent to Governor***

The Assembly and Senate passed a series of health reform bills before the August 31<sup>st</sup> deadline, giving Governor Jerry Brown (D) until the end of September to sign or veto them.

The most prominent measure (S.B. 910) sponsored by Senator Ed Hernandez (D), chair of the Health Committee, would ban the sale of all short-term health plans that expire in less than 364 days, starting in 2019. The bill, which the Governor is expected to sign, would be by far the broadest restriction sought by any state since Trump Administration regulations greatly expanded the use of short-term coverage that does not need to comply with the Affordable Care Act (see Update for Week of August 13<sup>th</sup>).

The federal Department of Health and Human Services this month finalized a rule extending the amount of time consumers can be on short-term plans from three months to almost 12 months, after which they can be renewed for up to three years (see Update for Week of August 13<sup>th</sup>). However, the HHS rule allows states to regulate the sale of such plans on their own terms and several including Colorado, Hawaii, Maryland, Vermont, and Washington (see below) have already taken action to restrict their use.

S.B. 910 is backed by a broad range of consumer groups and insurers (including Blue Shield of California and Kaiser Permanente) (see Update for Week of May 28<sup>th</sup>).

The legislature also sent S.B. 1375 to the Governor (likewise sponsored by Senator Hernandez), 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 could 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 8<sup>th</sup>). 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 16<sup>th</sup>). America’s Health Insurance Plans (AHIP) predicted that average premiums would increase by up to 5.7 percent next year as a result of both short-term and AHPs (see Update for Week of May 28<sup>th</sup>).

An additional bill now on the Governor’s desk (S.B. 1108) 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 7<sup>th</sup>).

The Assembly unanimously approved S.B. 1021 this week, 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 (see Update for Week of May 7<sup>th</sup>).

Other health reform bills sent to the Governor include A.B. 2472, which would create a California Council on Health Care Delivery Systems to study the feasibility of offering a public option within Covered California. A.B. 2499 would also codify the ACA’s medical-loss ratios (which limit insurer profit and overhead) into state law.



***Legislature passes bill creating new guardrails for third-party premium assistance***

The Assembly and Senate have passed heavily-amended legislation this week that seeks to create guardrails for premium assistance provided non-profit charitable organizations like PSI, sending the measure onto Governor Jerry Brown (D) who has not indicated whether he will sign it.

The legislation (S.B. 1156) was intended to address concerns by the federal Department of Health and Human Services (HHS) that third-party premium assistance was being used by dialysis providers and/or suppliers to inappropriately steer consumers eligible for either Medicare or Medicaid into private individual market plans where reimbursement could be as much as ten times higher. However, the guardrails proposed in initial versions of the bill went beyond those proposed by HHS and effectively lumped independent bona-fide charities like PSI in with those who provide assistance primarily to dialysis patients (who are largely on Medicare).

PSI Government Relations worked successfully with the California Chronic Care Coalition to remove provisions from the final bill that would prevented independent bona-fide charities from providing premium assistance to persons with specific medical diagnoses (see Update for Week of May 7<sup>th</sup>). However, non-profit foundations providing third-party premium assistance must still (1) provide the assistance for a full plan year, (2) inform applicants of all available coverage options (including Medicare and Medicaid) without steering, directing, or advising the applicant into or away from any specific option, and (3) agree that financial assistance is not conditioned on the use of specific facility or health care provider.

If these conditions are not met, S.B. 1156 caps reimbursement for covered services at the lower of the insured's contract rate or their Medicare payment. This effectively ensures that dialysis centers or other "financially-interested providers" cannot use premium assistance to steer patients towards higher-reimbursing plans.

Regardless of whether these conditions are met, insurers must still accept third-party premium assistance payments from any federal or state health program (including the federal Ryan White HIV/AIDS Program), as well as Native American tribes, consistent with federal regulations (see Update for Week of June 2, 2014). PSI also continues to back federal legislation (H.R. 3976) that would amend these federal regulations so that insurers must also accept premium (and cost-sharing) assistance from non-profit charitable organizations. That bill now has at least 171 bipartisan cosponsors.

Delaware

***ACA Marketplace premiums to increase by only three percent on average***

The Department of Insurance approved Marketplace premiums this week for 2019 for Highmark Blue Cross and Blue Shield, the only insurer participating in Choose Health Delaware.

Delaware will remain one of six states with only one Marketplace insurer, down from eight this year (see Update for Week of November 6<sup>th</sup>). The departure of Aetna last year and the Trump Administration's decision to eliminate ACA cost-sharing reductions (CSRs) shortly before the start of enrollment resulted in Highmark receiving a 25 percent average rate hike for the 2018 plan year. However, Highmark received only a three percent increase for the coming year (down from the 5.7 percent they requested), which analysts noted would actually be a seven percent decrease if not for the ten percent bump Highmark was granted due to the Congressional repeal of the individual mandate tax penalties under the ACA (see Update for Week of December 18<sup>th</sup>).

Delaware was one of five states that allowed insurers to increase 2018 premiums by an equivalent amount across all metal tiers in order to compensate for the sudden loss of the CSRs. The majority of states instead allowed increases only for the silver-tier plans to which the CSRs were tied and the Department of Insurance allowed Highmark to adopt that "silver-loading" approach for 2019 after the Trump Administration elected not to prohibit "silver-loading" until 2020 (see Update for Week of June 11<sup>th</sup>).

The Department also announced that Highmark will be issuing consumers in the ACA's small group Marketplace more than \$5 million in rebates after the insurer exceeded the ACA's medical-loss ratio (or cap on profits and administrative expenses) for last year. Consumers will receive the rebates by September 30<sup>th</sup>.

## Florida

### ***Marketplace insurers receive smallest premium increases since inception***

Approved premiums released this week by the Office of Insurance Regulation (OIR) reveal that Marketplace insurers will receive their lowest increases since the Affordable Care Act (ACA) was fully implemented.

The seven insurers participating in the Marketplace for 2019 will receive a 5.2 percent average increase, which OIR reduced from the 8.8 percent average they initially sought (see Update for Week of June 25<sup>th</sup>). Dominant carrier Florida Blue, the only insurer offering coverage statewide, received only a 2.4 percent increase on average (reduced from their proposed 10.5 percent hike).

Molina had threatened to leave the Marketplace after its Medicaid managed care contract was not renewed, just as it did in New Mexico where it is the dominant Marketplace carrier (see Update for Week of June 11<sup>th</sup>). Florida ultimately relented and allowed to Molina to serve Medicaid enrollees in two regions of the state. However, OIR reduced Molina's 9.5 percent proposed rate hike for Marketplace consumers down to a 1.5 percent average decrease—making it the only Marketplace insurer not granted any increase for 2019.

CIGNA, which pulled out the Marketplace in 2015, had their proposed premiums for other individual coverage reduced by OIR from a staggering average of 30.2 percent down to only ten percent.

The meager increases are a stark contrast to 2018 premiums, which increased by an average of 44.7 percent after the Trump Administration eliminated ACA cost-sharing reductions shortly before the start of open enrollment (see Update for Week of November 6<sup>th</sup>). Because Florida is a federally-facilitated Marketplace, the Trump Administration will have to approve the final premiums prior to the November 1<sup>st</sup> start of open enrollment.

Despite a 2.5 percent drop in enrollment from 2017, Florida continued this year to lead all states with more than 1.7 million Marketplace consumers (see Update for Week of February 12<sup>th</sup>).

More than 12.5 percent of Floridians are covered by individual market health plans, by far the highest rate of any state and nearly double the national average.

## Illinois

### ***Republican governor vetoes consumer protection bills***

Governor Bruce Rauner (R) vetoed two bills last week that sought to protect consumers from Trump Administration efforts to weaken consumer protections required by the Affordable Care Act (ACA).

The first measure (H.B. 4165) would have prevented state agencies from applying for any federal waiver that would "reduce or eliminate any protection or coverage" provided by the ACA without the approval of the General Assembly, including the law's minimum essential health benefits packages and prohibitions on insurer denials for pre-existing conditions (see Update for Week of June 25<sup>th</sup>). It also sought to prohibit any state agencies from applying for a federal waiver that would result in more restrictive standards, methodologies, or procedures for the Medicaid program.

The second measure (H.B. 2624) would limit the use of short-term health plans that do not comply with the ACA to no more than 181 days, instead of the 364 day limit that the Trump Administration finalized in recent regulations (see

Update for Week of August 13<sup>th</sup>). The Obama Administration had limited short-term health plans to no more than 90 days (see Update for Week of June 20, 2016).

#### Kentucky

##### ***Federal court dismisses governor's lawsuit against Medicaid enrollees opposing work requirements***

A federal judge appointed by President George W. Bush has dismissed the effort by Governor Matt Bevin (R) to countersue 16 Medicaid enrollees who successfully challenged the new work requirements he added for Medicaid adults.

Kentucky had been the first state to win federal approval to add work requirements for newly-eligible Medicaid adults earlier this year (see Update for Week of January 8<sup>th</sup>). However, the U.S. District Court for the District of Columbia invalidated the Trump Administration's approval of Kentucky's work requirements earlier this summer, with Judge James Boasberg concluding that the Administration and state officials "never adequately considered" that roughly 95,000 enrollees would lose coverage from "arbitrary" and "capricious" requirements that were "inconsistent with Medicaid's fundamental purpose of providing access to health care" (see Update for Week of June 25<sup>th</sup>). The National Health Law Program and Southern Poverty Law Center filed an analogous challenge last week before the very same judge challenging comparable work requirements that Arkansas put into effect on June 1<sup>st</sup> (see Update for Week of August 13<sup>th</sup>).

Because Judge Boasberg was appointed by President Obama, Governor Bevin had first unsuccessfully tried to transfer the case to the Eastern District of Kentucky, where all but one judge is a Republican appointee, before filing a countersuit against the 16 Kentucky Medicaid plaintiffs in that jurisdiction (see Update for Week of February 26<sup>th</sup>). However, Judge Gregory Van Tatenhove with the Eastern District of Kentucky concluded that the proper venue for the case was in the same District of Columbia court deciding the legality of the federal approval for the state's waiver request and that the Governor failed to establish jurisdiction in Kentucky.

The Governor issued an executive order earlier this year that would terminate the state's entire Medicaid expansion under the ACA (which was enacted by his Democratic predecessor) if the appellate courts also invalidate the work requirements (see Update for Week of February 12<sup>th</sup>).

#### Louisiana

##### ***New study shows Medicaid expansion halved uninsured rate in two years***

Governor John Bel Edwards (D) trumpeted a new study released this week from Louisiana State University, which shows that the number of Louisiana adults without health insurance has been cut in half since the state expanded its Medicaid program in July 2016.

Governor Edwards expanded Medicaid via executive order promptly after taking office over the staunch opposition of conservative lawmakers (see Update for Week of January 4, 2016). At the time, Louisiana had one of the nation's highest rates of non-elderly uninsured adults (at nearly 23 percent). The Louisiana Health Insurance Survey (conducted every two years by LSU) found that that number had now dropped to 11.4 percent after adding roughly 474,000 adults to the Medicaid program.

Medicaid now covers about 21 percent of all Louisiana adults, while 53 percent get health insurance through their employers.

#### Maine

##### ***Supreme Court says governor can no longer delay voter-mandated Medicaid expansion***

The Supreme Judicial Court ruled this week that Governor Paul LePage (R) must submit the required paperwork to the federal government needed to expand Medicaid under the Affordable Care Act (ACA).

Maine became the first state last fall to pass a voter referendum mandating the ACA expansion (see Update for Week of November 6<sup>th</sup>). However, the governor, who vetoed six earlier attempts by the Democratically-controlled legislature to expand Medicaid, vowed that he would “go to jail” before allowing the expansion, insisting that Maine’s share of the costs would be at least twice as high as projected (see Update for Week of December 18<sup>th</sup>).

Consumer and provider groups sued the governor after he missed the April 3<sup>rd</sup> deadline to submit the state plan amendment (SPA) that was mandated by the voter referendum (see Update for Week of May 7<sup>th</sup>). The lower Superior Court ruled in their favor, ordering the governor to submit the SPA by June 11<sup>th</sup> so that the expansion could still start as planned on July 2<sup>nd</sup> (see Update for Week of June 11<sup>th</sup>). However, the Supreme Judicial Court agreed to stay that ruling while the governor appealed (see Update for Week of June 25<sup>th</sup>).

In the interim, Governor LePage vetoed the legislature’s \$55 million appropriation for the legislation, which Democrats were unable to overrule (see Update for Week of July 7<sup>th</sup>). However, the lower court had found that Maine had ample 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 any appropriation (see Update for Week of June 11<sup>th</sup>). The Supreme Judicial Court concurred with the lower court’s finding and concluded that the governor was required to expand the program as mandated by the voters, regardless of whether a specific appropriation had been enacted.

In its 6-1 decision, the Supreme Judicial Court also directed the lower court to resolve “any issues that may have arisen” out of the governor’s willful decision to miss the voter-mandated effective date for the expansion. Governor LePage, who is termed out after this year, did not immediately indicate whether he would comply with the court’s order.

#### Maryland

#### ***Maryland becomes seventh state with federal approval to mitigate rate hikes through reinsurance program***

The Trump Administration approved Maryland’s requested State Innovation Waiver this week allowing it to mitigate premium spikes in the individual market by compensating insurers for exceptional claims.

The waiver, which is authorized by Section 1332 of the Affordable Care Act, allows Maryland to implement legislation enacted earlier this year, which would use 2.75 percent assessment on insurers and roughly \$380 million in windfall savings from the federal tax reform bill to fund reinsurance payments for plan years 2019 and 2020 (see Update for Week of April 16<sup>th</sup>). It is the seventh such waiver granted by the Trump Administration following the lead of Alaska and Minnesota, who were able to dramatically reduce premiums via reinsurance programs (see Update for Week of December 18<sup>th</sup>). Maine, Oregon, New Jersey, and Wisconsin have also received approved reinsurance waivers while two requests from Idaho and Louisiana remain pending at least six more are expected to be submitted through this year (see Update for Week of August 13<sup>th</sup>).

Based on the experience of other states, the reinsurance payments are expected to dramatically mitigate proposed premium increases that averaged more than 30 percent for plan year 2019, including a staggering 94 percent rate hike sought by dominant carrier CareFirst Blue Cross Blue Shield (see Update for Week of April 16<sup>th</sup>). They will reimburse insurers for 80 percent of claims between \$20,000 and \$250,000.

#### Nebraska

#### ***Lower court dismisses Republican lawsuit to block Medicaid expansion ballot referendum***

Lancaster Country District Court Judge Darla Ideus dismissed a lawsuit this week that sought to prevent voters from deciding this fall whether Nebraska should expand Medicaid under the Affordable Care Act (ACA).

The lawsuit was filed by Senator Lydia Brasch (R) and former Senator Mark Christensen (R) after the consumer group Insure the Good Life submitted far more than the 84,268 signatures to qualify the voter referendum for the November ballot (see Update for Week of July 9<sup>th</sup>). Secretary of State John Gale has already certified more than 105,000



signatures as valid, meaning the referendum cannot be blocked unless an appellate court strikes it down prior to the September 14<sup>th</sup> certification deadline.

Nebraska would be the third state behind Idaho and Utah with a Medicaid expansion ballot referendum this fall (see Update for Week of June 11<sup>th</sup>). Maine became the first state last year where Medicaid expansion was approved by the voters (see Update for Week of November 6<sup>th</sup>), although Maine's governor has refused to implement the expansion despite two court orders (see above).

#### Tennessee

##### ***Marketplace consumers to see increased competition, premium decreases for 2019***

The Department of Commerce and Insurance announced approved premiums last week for the five insurers participating in the Affordable Care Act (ACA) Marketplace operated in Tennessee.

Commissioner Julie Mix McPeak (R), a long-time critic of the ACA, noted that increased competition in metro areas from two new insurers (Bright Health and Celtic Insurance) resulted in first-time decreases for two of the Marketplace's longest-serving carriers. Dominant insurer BlueCross BlueShield (BCBS) of Tennessee (which provides statewide coverage except for Memphis and Nashville areas) will lower premiums by nearly 15 percent on average, reducing its top premium to nearly \$3,110 per month (which is still the highest in the Marketplace). CIGNA (which is adding Knoxville to its previous service areas in Memphis, Nashville, and the Tri-Cities) will decrease their rates nearly 13 percent, with the top rate falling to \$2,966.

The decreases are a dramatic departure from a year ago, when premium increases averaged 62 and 46 percent for BCBS and CIGNA respectively.

Oscar Health, which entered the Marketplace last year in order to fill "bare counties" (see Update for Weeks of June 12 and 19, 2017), is the only insurer raising premiums, with an average increase of nearly 11 percent. Its top premium will be \$2,345 per month.

#### Washington

##### ***Insurance commissioner seeks to restrict short-term health plans to 90 days***

Insurance Commissioner Mike Kreidler (D) issue a proposed rule last week that seeks to restrict the sale of short-term limited duration health plans beyond three months, prohibit their renewal, and require enhanced disclosure to consumers about the limitations of coverage.

Under federal regulations finalized last month, short-term health plans need not comply with key consumer protections in the Affordable Care Act (ACA) (such as essential health benefits and prohibitions on pre-existing condition discrimination), can extend up to 364 days (the pre-ACA limit), and can be renewed up to 36 months (see Update for Week of August 13<sup>th</sup>). However, the federal rule also lets sets insurance regulators set their own standards.

The 90-day limit chose by the Insurance Commissioner is the same as that set by the Obama Administration following the full implementation of the ACA (see Update for Week of June 20, 2016).

Public comments on the proposed rule are due by September 24<sup>th</sup>. If finalized, Washington would join states such as California, Colorado, Hawaii, Maryland, and Vermont in taking action to combat the federal loosening of short-term plan restrictions (see Update for Week of August 30<sup>th</sup>). The Republican governor of Illinois vetoed legislation this week that sought to impose a 180-day limit on short-term plans (see above).