PATIENT SERVICES INCORPORATED

# Health Reform Update – Week of November 12, 2018

## CONGRESS

***Democratic electoral gains will greatly impact Medicaid expansion, other health reforms***

The mid-term elections this week delivered Democrats not only control of the U.S House of Representatives, but a net gain of at least seven governorships and roughly 325 state legislative seats.

The anticipated "blue wave" carries major implications for health reform. At the federal level, the likely Democratic gain of at least 38 House seats means that Congressional Republicans can no longer unilaterally repeal or weaken key provisions of the Affordable Care Act (ACA), place per capita caps on Medicaid spending, or convert Medicare into a voucher program.

However, the greatest impact occurred at the state level, where voters in three states (Idaho, Nebraska, and Utah) approved referendums mandating that their state participate in the ACA's Medicaid expansion, while new Democratic governors in Kansas, Maine, and Wisconsin remove major obstacles to expansion in those states and also make it likely that they will cancel plans to impose work requirements for newly-eligible adults and weaken ACA requirements through federal waivers. In addition, new Democratic governors in New Mexico and Illinois (see below) are expected to result in the creation of Medicaid "buy-in" options for those with low-to-moderate incomes (see Update for Week of January 22nd), while Democratic control of the Colorado Senate should remove the lone roadblock to legislation creating a Medicaid buy-in, reinsurance program, and state subsidies for those ineligible for ACA tax credits (see Update for Week of May 7th).

Republicans had controlled an unprecedented 33 governorships before the election, but the partisan split is now almost equal. Democrats recovered nearly a third of the state legislative seats that they lost since 2010. Most notably, they gained at least 15 seats in North Carolina to wipe out the Republican supermajority in both chambers (see below), as well as eliminate supermajorities in the Michigan Senate and Pennsylvania Senate. Democrats also gained supermajorities in both chambers of the California and Oregon legislatures, as well as at least one chamber in Delaware, Illinois (see below), and Nevada.

As a result, Democrats now control every statewide office in California, Michigan, Nevada, and Wisconsin and maintain "trifectas" (governorship, House, and Senate) in 14 states (up from six last year). Republicans still hold "trifectas" in 23 states after losing full control in Kansas, Michigan, New Hampshire, and Wisconsin (though gaining a "trifecta" in Alaska). For the first time in more than a century, only one state (Minnesota) will have a 2019 legislature with divided control.

Democrats also "flipped" at least four Attorneys General seats in Colorado, Michigan, Nevada, and Wisconsin and now hold a 27-23 majority nationwide. Wisconsin Attorney General Brad Schimel (R) was a lead plaintiff in the Texas lawsuit brought by 18 Republican Attorneys General (and two Republican governors) seeking to strike down the entire ACA, including the protections against pre-existing condition discrimination (see Update for Week of September 10th). His successor has pledged to withdraw Wisconsin from that lawsuit and other Democratic newcomers are expected to follow.

Republicans were able to expand their majority in the U.S. Senate by two seats. Furthermore, existing Medicaid expansions in Alaska and Ohio may be eliminated or modified by new Republican governors while Montana voters failed to approve a tobacco tax required to extend their expansion past July 1st. To date, no state has eliminated a Medicaid expansion under the ACA, although new Republican governors in Arkansas and Kentucky did impose additional work requirements (see Update for Week of June 25th).

It is not immediately clear what the impact of divided Congressional control will mean for the President's "blueprint" to reduce prescription drug prices (see Update for Week of May 7th). There already is bipartisan consensus on legislation to restrict the use of "pay-to-delay" patent litigation settlements between generic and brand-name drugmakers (see Update for Weeks of February 8 and 15, 2016), as well as some agreement on increasing oversight over the federal Section 340B Drug Discount Program (see Update for Week of July 9th) and expanding Medicaid drug rebates. However, the Pharmaceutical Research and Manufacturers of America (PhRMA) expressed concern that losing the House could compel President Trump to make deals with Democratic leaders to advance more expansive reforms that he supported as a candidate but did not include in his "blueprint", such as giving Medicare Part D the authority to negotiate drug prices or allowing the importation of lower-cost prescription drugs from other countries.

Rep. Frank Pallone (D-NJ), who is expected to again become chair of the House Energy and Commerce Committee, announced this week that negotiation authority for Part D would be a priority for his committee.

## FEDERAL AGENCIES

***Initial Marketplace enrollment figures are slightly below 2018 pace***

The Centers for Medicare and Medicaid Services (CMS) announced this week that just over 1.1 million consumers have selected Marketplace plans through the federal web portal during the first ten days of the 2019 open enrollment period that started November 1st.

The pace of enrollment lags behind last year's open enrollment period, when nearly 17,000 more consumers signed-up per day. Enrollment for the full 2018 enrollment period fell from the year before with the Government Accountability Office (GAO) recently attributing Trump Administration decisions to slash the marketing and advertising budget for federally-facilitated Marketplaces (FFM) by 90 percent and cut the sign-up period in half for much of the decline (see Update for Week of August 28th).

The federal web portal is being used by 39 states during the 2019 open enrollment period, which ends December 15th. Several state-based Marketplaces have extended their enrollment period, with California, the District of Columbia, and New York maintaining the full 12-week period (see Update for Week of July 23rd).

House Democratic leaders have pledged to use their new oversight authority to review the Trump Administration's cuts to Marketplace outreach when they assume control of the House in January (see above).

***Insurers to petition U.S. Supreme Court over outstanding ACA risk corridor payments***

The dispute over whether the Centers for Medicare and Medicaid Services (CMS) must pay insurers more than $12 billion in outstanding risk corridor payments under the Affordable Care Act (ACA) appears to be headed for the U.S. Supreme Court.

The U.S. Court of Appeals for the Federal Circuit refused last week to reconsider an earlier decision by a three-judge panel that sided with CMS. Six of the nine judges agreed with insurers that the ACA obligated CMS to make the payments under the temporary risk corridor program that expired after 2016. However, they concluded that successful efforts by Congressional Republicans to subsequently block those payments through appropriations riders supersede the ACA statute (see Update for Week of December 15, 2014).

The lower courts had initially sided with Moda Health Plan and Land of Lincoln Mutual Insurance (see Update for Week of February 27, 2017) but that decision was overturned earlier this year in a 2-1 ruling from the three-judge panel (see Update for Week of June 11th). Blue Cross Blue Shield of North Carolina and Maine Community Health Options (MHCO), which had filed similar lawsuits, joined in the appeal.

Both Moda and MCHO announced that they would promptly appeal to the U.S. Supreme Court. The insurers argue that they agreed to participate in the new ACA Marketplaces only because the federal government was obligated under the CMS to reimburse them for losses over a designated percentage and the unknown risk they were assuming caused their risk pools to be more heavily skewed towards high-cost and sicker populations than they were able to project. They insisted that allowing Congress to subsequently "abrogate its obligation to pay through appropriations riders, after it has induced reliance on its promise to pay" would severely undermine the federal government's "credibility as a reliable business partner" and make insurers less willing to participate in future years.

At least 20 insurers nationwide have filed lawsuits seeking outstanding risk corridor payments. Four (including MCHO and Land of Lincoln) 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).

***CMS relaxes consumer protections for Medicaid managed care plans***

The Centers for Medicare and Medicaid Services (CMS) issued proposed regulations last week that would roll back the new standards that the Obama Administration imposed on Medicaid managed care plans.

The previous rule promulgated in 2016 had been the first time CMS modernized Medicaid managed care standards in more than a decade, following a dramatic expansion in state reliance on managed care (see Update for Week of May 16, 2016). More than 80 percent of all Medicaid enrollees nationwide are now enrolled in managed care plans, according to the Kaiser Family Foundation.

In the 2016 rule, CMS capped profit and overhead for Medicaid managed care plans at 15 percent, imposing the identical medical-loss ratio that the Affordable Care Act (ACA) placed on large-group plans. It also required Medicaid managed care plans to comply with the same quality standards and star rating system as private managed care plans under Medicare Advantage and created new time and distance standards for network adequacy (i.e. providers must be within 30 miles or 30 minutes of where consumers live). .

The Obama Administration rule was intended to provide uniformity nationwide so that consumers could more easily compare plans across states. However, the new proposed rule would eliminate the time and distance standards and give states leeway to create more flexible network adequacy standards that incorporates local factors such as the availability of telehealth in rural areas, the ratio of providers to enrollees, and wait times for appointments. States would also have more discretion in how to set payment rates for Medicare managed care plans (replacing specific capitated rates with a rate range of five percent), use their own quality measures to assess plan performance, and notify enrollees about "critical" information.

CMS Administrator Seema Verma said that the changes were needed "to reset and restore the federal-state relationship, while at the same time modernizing the program to deliver better outcomes." However, consumer groups such as Families USA quickly raised concerns that they would adversely impact access to care as states are allowed to create "much smaller set of measures by which evaluate plan and state quality."

***CMS to increase audits of ACA premium tax credit eligibility***

The Centers for Medicare and Medicaid Services (CMS) released proposed regulations this week that would increase agency oversight over consumer eligibility for the premium tax credits offered by the Affordable Care Act (ACA).

CMS stated that the rule was needed to align agency practice with recommendations from the Department of Health and Human Services (HHS) Office of Inspector General (OIG) and the Government Accountability Office (GAO). The increased audits would help ensure that consumers are not improperly enrolled in both Marketplace coverage and

other federal health programs such as Medicare, Medicaid, CHIP, or the Basic Health Plan option under the ACA that was created in New York and Minnesota (see Update for Weeks of May 29 and June 5, 2017).

Under the rule, all insurers offering qualified health plans (QHPs) must also separate funds from the ACA premium tax credits for services not covered under state or federal law (such as abortion services).

The heightened reporting requirements would apply not only to federally-facilitated Marketplaces operated by CMS for 39 states, but also the 12 state-based Marketplaces (SBMs).

***HHS seeks to alter Medicare Part B drug reimbursement based on international pricing***

The Department of Health and Human Services (HHS) issued a draft proposal last week that would create an International Pricing Index (IPI) payment model in order to more closely align payment for Medicare Part B drugs with drug prices in other countries.

The model would be implemented through the Center for Medicare and Medicaid Innovation (CMMI), which was created by the Affordable Care Act (ACA) as a division within the Centers for Medicare and Medicaid Services (CMS). It would apply only to a randomly-selected half of the United States and be used only for single-source and biologic drugs over the first two years.

Under the new proposal, HHS is considering several alternatives to the current Average Sales Price (ASP) plus six percent add-on payment. Payment under the model would no longer be tied to drug prices and instead reimburse providers a set amount for storing and handling drugs.

The proposal caught stakeholders by surprise as it was not included as part of the President's drug pricing "blueprint" released last spring (see Update for Week of May 7th). It also goes further than the Obama Administration proposal to reform Medicare Part B drug pricing that simply reduced the mark-up received by physicians and hospitals. That proposed rule in 2016 drew intense opposition from drugmakers, providers, and bipartisan members of Congress and was quickly withdrawn.

Public comments on CMS' latest proposal will be accepted through December 31st and a proposed rule is planned for March 2019. The Pharmaceutical Research and Manufacturers of America (PhRMA) has already sharply criticized the proposal as "price controls" while consumer advocates are largely questioning whether it will restrict access to critical or life-saving treatments.

Congressional Democrats that will be assuming control of the House in January largely expressed skepticism this week about the CMS proposal but agreed to hold hearings next year to discuss it.

## STATES

<u>Idaho</u>

***New Governor will respect voter mandate to expand Medicaid but likely seek new work requirement***

More than 60 percent of voters approved Proposition 2 this week, making Idaho the latest state to participate in the Medicaid expansion under the Affordable Care Act (ACA).

The referendum mandates that Idaho expand Medicaid by January 1, 2020. However, it does not specify a funding mechanism for the state share of costs, which the ACA caps at ten percent. That decision will have to be worked out by the legislature before the Department of Health and Welfare can submit the required State Plan Amendment to the federal government.

The expansion had the support of outgoing Governor Butch Otter (R), who had sought to expand as early as 2013 following the unanimous recommendation of a legislative workgroup but backed-off in the face of staunch opposition from conservative lawmakers (see Update for Week of April 18, 2016). He will be replaced in January by Lt. Gov. Brad Little (R) who has pledged to respect the will of the voters regarding Medicaid expansion but stated he would seek to create an "Idaho solution", which is widely believed to include the imposition of a work requirement for newly-approved enrollees, similar to measures the Trump Administration has already approved for five conservative-leaning states (see Update for Week of October 29th).

The expansion will have a major impact in Idaho, whose restrictive Medicaid program only covers pregnant women with incomes under 138 percent of the federal poverty level (FPL) and the disabled and parents with dependent children with incomes below 50 percent of FPL. It does not cover childless adults.

Under the expansion, Medicaid will cover everyone earning up to 138 percent of FPL. This will add roughly 69,000 Idahoans to the Medicaid rolls and reduce the state's uninsured rate from 14.6 percent to 9.9 percent, according to projections from the Urban Institute.

Illinois

***Legislature overrides veto of bill restricting use of short-term health plans***

The legislature voted this week to override the gubernatorial veto of H.B. 2624, which restricted the use of short-term health plans that fail to comply with the Affordable Care Act (ACA).

Governor Bruce Rauner (R) had vetoed the bill, which sought to impose a 181 day limit, instead of the 364 day limit that the Trump Administration finalized in recent regulations (see Update for Week of August 27th). The Obama Administration had limited short-term health plans to no more than 90 days (see Update for Week of June 20, 2016). Several states including Colorado, Hawaii, Maryland, and Vermont have imposed comparable 90-180 day limits on short-term health plans while California outlawed them entirely (see Update for Week of August 27th).

Rauner lost his re-election bid last week to J.B. Pritzker (D), heir to the Hyatt Hotel fortune who is now officially the wealthiest elected official in the country. Governor-elect Pritzker has proposed legislation that would let ACA Marketplace consumers use premium tax credits to instead purchase coverage in Medicaid.

With the governorship victory, Illinois is now one of 14 states where Democrats hold a "trifecta" over the three major branches. Democrats swept all statewide races and their six-seat gain in the House gave them "supermajority" status in that chamber.

Michigan

***Medicaid gets federal waiver to implement value-based purchasing for prescription drugs***

The Administrator for the Centers for Medicare and Medicaid Services (CMS) announced this week that it has approved a federal waiver allowing the Michigan Department of Health and Human Services to negotiate supplemental Medicaid rebates with drug manufacturers based on whether certain clinical outcomes are achieved.

This "value-based purchasing" plan is similar to the waiver CMS approved earlier this year for Oklahoma (see Update for Week of June 25th) and was part of the drug pricing "blueprint" released by the President (see Update for Week of May 7th). According to Administrator Seema Verma, they will "empower" states to "demand results from drug manufacturers in exchange for paying for medicines."

Under the waiver, both manufacturers and the Medicaid program would have to agree on the outcome measure in advance, as well as the population to which it will be applied. In order for the waiver to be renewed, the arrangement would have to decrease Medicaid drug expenditures.

Montana

***Medicaid expansion in jeopardy after financing mechanism fails to get voter approval***

Voters rejected a ballot referendum last week that would have approved the funding mechanism needed to continue Montana's existing Medicaid expansion under the Affordable Care Act (ACA) beyond its legislated sunset on June 30th.

The referendum (I-185) would have imposed an additional $2 per tax on cigarettes and a first-time tax on other tobacco products. The initiative was backed and largely funded by the Montana Hospital Association, who insisted they had little alternative since Republicans who maintain sizeable majorities in both the House and Senate had refused to support any other extension of the expansion.

However, two tobacco companies poured more than $17 million into defeating I-185, more than doubling the funding from supporters and making it by far the most expensive ballot referendum in the state's history.

Governor Steve Bullock (D) insisted the legislature would be able to approve an alternative funding mechanism before the expansion expires but acknowledged that any compromise would likely have to include work requirements for newly-eligible populations that the Trump Administration has already approved for five conservative-leaning states (see Update for Week of October 29th). Rep. Nancy Balance (R) agreed, although she argued that the legislature should also impose higher premiums and take other actions to correct "deficiencies" in the current expansion.

Work requirements were part of the initial legislative compromise authorizing the expansion but were stripped out by the Obama Administration, which refused to approve work requirements for any state (see Update for Week of November 30, 2015).

No state has discontinued an existing Medicaid expansion under the ACA though new Republican governors in Arkansas and Kentucky did modify their state's expansions to incorporate work requirements (see Update for Week of June 25th). Nearly 92,000 Montanans are currently enrolled in the expansion program saving Montana roughly $22 million as recently as fiscal year 2017.

Nebraska

***Voters approve full Medicaid expansion over objections of Governor***

More than 53 percent of voters approved Initiative 427 this week, making Nebraska one of four states where voters were able to force participation in the Medicaid expansion under the Affordable Care Act (ACA) over the opposition of conservative lawmakers.

The initiative requires the Department of Health and Human Services to submit the required State Plan Amendment to the federal government by April 1, 2019 without any legislative changes that would require federal waivers. According to the Urban Institute, it will expand Medicaid to an estimated 45,000 Nebraskans earning up to 138 percent of the federal poverty level and reduce the state's uninsured rate from 12.4 percent to 9.6 percent next year, all while bringing Nebraska more than $600,000 per year in ACA matching funds. The University of Nebraska at Kearney predicted it would result in a net gain of $1 billion in economic benefit to the state over the first five years (see Update for Weeks of April 6 and 13, 2015).

The ballot referendum was strongly opposed by Governor Pete Ricketts (R), who was re-elected to a second term this week. Governor Ricketts and the technically non-partisan but decidely conservative legislature had blocked any form of Medicaid expansion arguing that the state's share of the costs (capped at ten percent in 2020 and beyond) would be unsustainable (see Update for Week of January 11, 2016). The Governor has not yet indicated how he will respond to passage of the initiative.

Maine became the first state last year with a voter-approved Medicaid expansion but outgoing Governor Paul LePage (R) refused to submit the required SPA until he was ordered to do so by the state Supreme Court (see Update for Week of September 10th). By contrast, Idaho's incoming Republican governor has pledged to respect his state's voter mandate to expand Medicaid, as has the Republican governor in Utah (see below) and newly-elected Democratic governor in Maine.

North Carolina

***Medicaid expansion on the table for 2019 session after Republicans lose supermajorities***

Democrats gained at least 15 legislative seats this week forcing Republican to lose the supermajority status that they have held in both the House and Senate since 2013.

Governor Roy Cooper (D) has had 20 of his 25 vetoes overridden by the Republican supermajorities since assuming office last year. However, Democratic gains are likely to lead to renewed debate over the last year's bill sponsored by four Republicans that would expand Medicaid under the Affordable Care Act (ACA).

That measure (H.B. 662) would follow the alternative model federally-approved two years ago for Indiana (see Update for Weeks of January 26 and February 2, 2015), in which those made newly-eligible would be required to pay premiums (of up to two percent of income) and be "engaged in activities that promote employment." The bill sponsors, which included a former hospital administrator, a physician, and a registered nurse, insisted the expansion would save North Carolina more than $45 million per year in traditional Medicaid expenses.

However, the bill met immediate resistance from Republican leaders who have blocked all Democratic efforts to expand Medicaid, including the temporary injunction they were granted against efforts by new Governor Roy Cooper (D) to enact a traditional Medicaid expansion through his executive authority (see Update for Week of January 30th). The General Assembly enacted legislation in 2013 that prohibits the governor from expanding Medicaid without legislative approval (see Update for Week of March 4, 2013).

Without supermajority status, the sponsors of H.B. 662 are urging the party to "own the expansion" and follow the lead of conservative lawmakers in states like neighboring Virginia who have conditioned the expansion on the imposition of work requirements for those made newly-eligible (see Update for Week of May 28th). Virginia Republicans had likewise staunchly opposed expansion until they lost supermajority status in the House of Delegates last year (see Update for Week of November 6, 2017).

Governor Cooper agreed to include Medicaid work requirements in any future expansion as part of the Medicare Reform Demonstration that the Trump Administration approved last month for North Carolina. However, the work requirements were rejected because the legislature has yet to pass authorizing legislation (see Update for Week of October 28th).

Utah

***Health department withdraws partial Medicaid expansion after voters approve full expansion***

Voters approved a ballot referendum last week that will expand Medicaid under the Affordable Care Act (ACA) to everyone earning up to 138 percent of the federal poverty level (FPL).

Because Proposition 3 enacted a traditional Medicaid expansion pursuant to the ACA, the state does not need to secure a federal waiver and can start enrolling the expanded population starting April 1st. The Department of Health promptly asked the Trump Administration to forgo consideration of the federal waiver they had requested last year after the legislature passed only a partial expansion up to 100 percent of FPL (see Update for Week of March 19th).

The measure will increase the state sales tax by 0.15 percent in order to pay for the state share of the expansion, which the ACA limits at no more than 10 percent of all expansion costs starting in 2020. The consumer advocacy group that put the referendum on the ballot, Utah Decides Healthcare, estimates that the expansion n, Utah Decides Healthcare, has estimated the increase will add $91 million in state revenue, which will trigger roughly $800 million in ACA matching funds to cover the cost for adding a projected 150,000 new Medicaid enrollees. The partial expansion approved by the legislature would have only expanded coverage to 70,000 new enrollees without bringing in federal funding (see Update for Week of March 19th).

Utah joins with Idaho and Nebraska, where voters enact similar Medicaid expansion referendums last week (see above). Maine was the first state last year where voters approved a Medicaid expansion over the opposition of state Republican leaders (see Update for Week of November 6, 2017).