

## Health Reform Update – Week of October 1, 2018

### CONGRESS

#### ***Spending bill boosts HHS funding while averting government shutdown***

President Trump signed spending legislation along with a continuing resolution last week that will keep the federal government operating until December 7<sup>th</sup>, avoiding the possibility of a controversial government shutdown just before the midterm elections in November.

The package includes the fiscal year 2019 Labor-HHS and Defense appropriations bill (H.R. 6157) and the Agriculture-FDA appropriations bill (H.R. 6147). It represented the first time that Congress has timely passed a bill to fund the Department of Health and Human Services (HHS) in more than 20 years.

The decision to pair HHS funding with defense spending made it unlikely that conservative lawmakers would vote it down. While the bill does not provide any new funding for the Affordable Care Act (ACA), it also did not cut funding for the first time since Republicans took control of Congress following the implementation of the health insurance reform law.

Overall, the measures provide HHS a roughly \$2.3 billion increase in funding, while the National Institutes of Health and Food and Drug Administration received a \$2 billion and \$159 million bump respectively.

#### ***President to sign bills banning pharmacy “gag clauses”, identifying “pay-to-delay” deals for biosimilars***

The House and Senate approved two measures last week by nearly unanimous margins that would ban the use of so-called “gag clauses” in pharmacy benefit manager (PBM) contracts.

The bills (S.2553 and S.2554) would prohibit clauses that prevent pharmacists from informing consumers when a prescription drug would be less costly without using health insurance. S.2553 would prohibit such clauses in the Medicare market, while S. 2554 would do so for commercial plans (see Update for Week of September 10<sup>th</sup>).

President Trump is expected to sign both measures as he tweeted his support last week and included the prohibitions as part of his drug pricing “blueprint” released earlier this year (see Update for Week of May 7<sup>th</sup>). They also are backed by the Pharmaceutical Care Management Association, which insists that most pharmacy benefit management companies already exclude “gag clauses”.

A lesser-noticed provision in S. 2554 also includes language to require manufacturers of biologic or biosimilar drugs any patent-litigation settlement to the Federal Trade Commission (FTC). This is an effort to enhance the ability of the FTC to review and potentially block “pay-to-delay” settlements that, according to the FTC, delays the introduction of lower-cost competing products by an average of 17 months and costs consumers roughly \$3.5 billion per year (see Update for Week of March 18, 2013). Currently, only manufacturers of small molecule drugs are required to report these settlements.

Since the Affordable Care Act (ACA) created a regulatory approval pathway for biosimilars, the FDA has approved 12 such competitors to biologic products, yet only three have made it to market. The FTC claims that undisclosed “pay-to-delay” agreements are a primary reason for the delay.

#### ***CBO predicts that Senate bill to facilitate generic drug approvals would save \$3.3 billion***

The Congressional Budget Office (CBO) projected last week that a Senate bill that would let generic or biosimilar competitors sue brand-name drug manufacturers who deny access to needed samples would accelerate the entry of

lower-cost drugs by 1-2 years and not only save the federal government \$3.3 billion over ten years but generate \$600 million in new revenue through lower premiums on federal health plans.

The *Creating and Restoring Equal Access to Equivalent Samples Act of 2018* (S.974) was introduced last spring by Senator Patrick Leahy (D). It has attracted equal numbers of Republican and Democratic cosponsors and cleared the Senate Judiciary Committee last summer after the Food and Drug Administration (FDA) publicized a list of 41 brand-name manufacturers that it claims have abused the Risk Evaluation and Mitigation Strategy (REMS) requirements to restrict access to samples of branded drugs that are necessary to conduct FDA-required tests to demonstrate bioequivalence (see Update for Week of May 28<sup>th</sup>).

However, legislative action on the bill (as well as its House counterpart) has stalled and it remains unclear whether the favorable CBO score will spur movement before the end of the year.

## **FEDERAL AGENCIES**

### ***Federal judge says insurers are entitled to reimbursement for terminated ACA cost-sharing reductions***

The United States Court of Federal Claims ruled last month that Montana Health CO-OP is entitled to \$5.3 million in Affordable Care Act (ACA) cost-sharing reductions (CSRs) for the last three months of 2017.

President Trump had terminated the CSRs shortly before the start of the 2018 open enrollment period (see Update for Week of November 6<sup>th</sup>) after Congressional Republicans obtained a lower court ruling declaring the CSRs to be invalid because no appropriation was authorized by the Republican-controlled Congress. However, Judge Elaine Kaplan (appointed by President Obama) held that “the statutory language [of the ACA] clearly and unambiguously imposes an obligation” on the federal government to reimburse insurers for cost-sharing reductions they had already provided to subscribers earning 100-250 percent of the federal poverty level for plan year 2017.

Judge Kaplan stressed that her ruling does not entirely conflict with the earlier decision by Judge Rosemary Collyer (appointed by President George W. Bush) with the U.S. District Court for the District of Columbia, as it acknowledged insurers could be reimbursed for outstanding obligations from a special account or “Judgement Fund” that the Department of Justice maintains to pay legal claims against the government.

If Judge Kaplan’s decision survives the all but certain appeal, it could have huge ramifications as the federal government would be forced to repay nearly \$2 billion in outstanding CSR payments from 2017. At least a dozen insurers are already part of a CSR class action in the U.S. Court of Federal Claims that was certified last spring and several similar cases remain pending.

Montana Health is one of only four remaining non-profit cooperatives that were created with ACA start-up loans. Most of the 23 CO-OPs were forced to dissolve due to federal shortfalls in funding they were due under the ACA risk corridor program (see Update for Week of November 30, 2015). The \$5.3 million that Montana Health will receive in outstanding CSR funding is critical to its survival as the CO-OP owes nearly 20 percent of its revenue to competing insurers under the ACA’s risk adjustment formula, which requires insurers with healthier risk pools to compensate insurers who took on sicker and more costly subscribers (see Update for Week of July 9<sup>th</sup>). Montana Health had used low premiums to successfully attract more subscribers than its two Marketplace competitors Blue Cross and Blue Shield of Montana and PacificSource. However, because the low premiums disproportionately attracted younger and healthier consumers, Montana Health has been forced to increase average premiums for next year by more than ten percent in order to minimize future risk adjustment payments, while BCBS will not need to increase premiums at all (see Update for Week of June 25<sup>th</sup>).

### ***Judge sets injunction hearing for newly-implemented rule allowing short-term health plans***

The U.S District Court for the District of Columbia has scheduled an October 26<sup>th</sup> hearing on a stakeholder request to block implementation of final regulations governing short-term health plans.

The rule, which went into effect on October 2<sup>nd</sup>, allows insurers to offer short-term coverage that fails to comply with key consumer protections in the Affordable Care Act (ACA) so long as the plans expire within 364 days (see Update for Week of August 13<sup>th</sup>). The Obama Administration had limited short-term coverage to no more than three months and several states have already acted to impose a comparable 90-day limit while California outlawed the short-term plans entirely (see below).

The lawsuit was brought by provider and consumer groups including the Association of Community Affiliated Plans, National Alliance on Mental Illness, Mental Health America, American Psychiatric Association, AIDS United, National Partnership for Women & Families, and Little Lobbyists (see Update for Week of August 13<sup>th</sup>). The plaintiffs argued that the final rule undermines the purpose and intent of the ACA and will irreparably harm the individual insurance market by siphoning away critical healthier and lower-cost consumers into “junk” coverage, effectively relegating ACA-compliant coverage into a high-risk pool.

Judge Richard Leon (appointed by President George W. Bush) ordered the Trump Administration to file their response to the motion for preliminary injunction by October 15<sup>th</sup>, while the plaintiffs must reply by October 22<sup>nd</sup>.

A dozen state attorneys general have already filed a separate lawsuit seeking to block implementation of Trump Administration rules allowing for similarly non-compliant association health plans (see Update for Week of August 13<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 being widely available (see Update for Week of May 28<sup>th</sup>).

### ***Proposed rule would let workers use employer HRA contributions to buy individual market coverage***

The White House Office of Management and Budget (OMB) is reviewing proposed regulations that would let employers use health reimbursement accounts (HRAs) to help workers purchase individual market coverage in or out of the Affordable Care Act (ACA) Marketplaces.

The rule stems from President Trump’s initial executive order directing the departments of Health and Human Services, Treasury, and Labor to find ways to increase the use of HRAs by allowing them to be used in conjunction with non-group coverage. The proposed rule, which must receive an OMB paperwork clearance before being published, would let workers receive a tax-free contribution from employers. However, it is not yet clear whether individual plans purchased with the contributions would become subject to the same regulations as group health plans or how the agencies will prevent workers from “double-dipping” if they are also eligible for ACA premium tax credits to purchase Marketplace coverage. The rule must also resolve whether workers could use the contributions to purchase non-ACA compliant coverage, such as the short-term health plans that were recently expanded by HHS (see Update for Week of August 13<sup>th</sup>).

The rule is expected to largely follow the *Small Business Healthcare Relief Act*, which was enacted by Congress in 2016 as part of the *21st Century Cures Act* (see Update for Week of December 5, 2016). This legislation created a new “qualified small employer health reimbursement arrangement” that small firms with less than 50 workers could use to provide employees with up to \$4,950 for single coverage and \$10,000 for family coverage.

### ***Medicare Advantage premiums hit three-year low due to increased competition***

The Centers for Medicare and Medicaid Services (CMS) disclosed this week that monthly premiums for Medicare Advantage (MA) plans will average \$28 for 2019.

The premiums are the lowest for the MA program in the last three years and are six percent lower than for 2018. According to CMS, nearly 83 percent of all MA enrollees will have the same or lower premium next year if they choose to stay in their current plan.

CMS attributed the decrease to increased competition, as MA enrollees will have 600 additional plan options for which to choose in 2019. More than 90 percent of Medicare enrollees will have access at least ten MA plans, compared to nearly 86 percent this year.

The agency predicts that MA enrollment will increase by 11.5 percent to a record high of 22.6 million next year, representing more than 36 percent of all Medicare beneficiaries

CMS released the MA data one day following a critical report from the Office of Inspector General for the Department of Health and Human Services, which concluded that MA plans may be denying claims to boost profits, citing the high rate of initial pre-authorization and payment denials that are overturned on appeal. CMS officials pledged to increase program oversight in response to the report.

The annual open enrollment period for Medicare Advantage plans opens October 15<sup>th</sup> and runs through December 7<sup>th</sup>.

#### ***Proposed rule would restrict immigration for those under Medicaid or Medicare Part D low-income subsidy***

The Department of Homeland Security (DHS) released proposed regulations last week that would expand the ability of the agency to deny visas or legal permanent residency to immigrants who have received any public benefits to which they are legally entitled.

The list of benefits that would potentially identify an immigrant as a “public charge” includes not only food stamps or public housing vouchers, but in an unprecedented move also includes Medicaid or the low-income subsidy under the Medicare Part D prescription drug program. The proposal is a sharp departure from current guidelines that have been in place since 1999 that explicitly barred DHS from considering non-cash benefits.

Under the proposed rule, an applicant’s receipt of even just one of these public benefits would be a “heavily-weighted negative factor” in determining their eligibility. Critics predict that it could impact more than 382,000 people per year who obtain permanent residence (i.e. “green” cards) and warned that it was essentially an effort to slash legal immigration from poorer countries without the need for Congressional approval.

DHS did modify the rule in response to a public outcry over earlier drafts, which would have penalized immigrants for the use of public benefits by dependents. The current rule will only evaluate public benefits used by the applicant.

## **HEALTH CARE COSTS**

### ***Despite moderate premium increases, workers continue to pay greater share of insurance costs***

The annual employer health benefits survey released this week by the Kaiser Family Foundation showed that employee share of health care costs continue to increase despite only a moderate rise in premiums.

Individuals receiving coverage through their employer will pay three percent more in annual premiums (up to an average of nearly \$7,000), while family coverage rose five percent to more than \$19,600 on average. These increases are roughly in line with those experienced in each of the past seven years, but continued to slightly outpace increases in wages and inflation.

However, workers now are responsible for 17 percent of individual plan costs on average and 28 percent for family coverage. The employee share has increased more rapidly than premium costs due to the continued spike in annual deductibles, which now average \$1,573. At least 85 percent of employer plans now require a deductible (up from 81 percent last year and 59 percent in 2008).

The result has been that while employee premium costs have increased by 55 percent over the past ten years, deductible costs have jumped by 212 percent over that time (or more than eight times faster than wages have grown). The survey found that 26 percent of those covered under employer plans now have annual deductibles of at least \$2,000.

## STATES

### ***Uninsured rates for low-income adults in rural areas declined three times faster in Medicaid expansion states***

A new study from the Georgetown University Health Policy Institute has found that the Medicaid expansion under the Affordable Care Act (ACA) has disparately benefited low-income adults living in rural areas.

According to researchers, the uninsured rate has dropped since the ACA was enacted in nearly all states, regardless of whether they participated in the ACA expansion. However, the sharpest declines occurred in the most rural areas of expansion states, as the uninsured rate for newly-eligible adults (those earning up to 138 percent of the federal poverty level) fell by more than half (35 percent to 16 percent), compared to only a six percent decline (from 38 to 32 percent) in non-expansion states.

The states that experienced the greatest declines in adult uninsured rates across rural areas were Arkansas, Colorado, Connecticut, Hawaii, Kentucky, Michigan, Nevada, New Mexico, Oregon, and West Virginia.

The non-expansion states with the widest coverage disparities between rural and metro areas are Virginia (which recently approved Medicaid expansion for next year), Utah (which will vote this fall on a Medicaid expansion referendum), Florida, and Missouri.

### California

#### ***Governor signs bills outlawing “junk” health insurance, Medicaid work requirements***

Governor Jerry Brown (D) signed a series of bills last week that make California the only state to prohibit insurers from offering short-term or association health plans that fail to comply with the Affordable Care Act (ACA), as well as preventing work requirements on those enrolled in Medicaid.

The most prominent measure (S.B. 910) sponsored by Senator Ed Hernandez (D), chair of the Health Committee, bans the sale of all short-term health plans that expire in less than 364 days, starting in 2019. The outright prohibition is by far the broadest restriction sought by any state since the Trump Administration 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 (HHS) 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, Delaware, Hawaii, Maryland, Vermont, and Washington have already taken action to restrict their use (see Update for Week of August 27<sup>th</sup>).

Governor Brown also signed S.B. 1375, which requires association health plans (AHPs) sought by the Trump Administration to comply with all ACA consumer protections. The U.S. Department of Labor recently finalized regulations that allow trade associations to sell employer-sponsored coverage 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 June 25<sup>th</sup>). Avalere Health, the Blue Cross Blue Shield Association, and state regulators continue warn that “broadly expanding the use of AHPs may lead to higher premiums” as younger and healthier consumers leave more comprehensive Marketplace coverage for cheaper limited-benefit coverage (see Update for Week of April 16<sup>th</sup>) and at least a dozen Democratic attorneys general have filed lawsuit seeking to block implementation of the final rule.

The newly-signed S.B. 1108 also prohibits any state agency from pursuing federal waivers 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>).

Additionally, Governor Brown signed legislation that 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 signed by the governor include A.B. 2472, which creates a California Council on Health Care Delivery Systems to study the feasibility of offering a public option within Covered California. A.B. 2499 also codifies the ACA’s medical-loss ratios (which limit insurer profit and overhead) into state law.

### ***Governor vetoes bill creating new guardrails for third-party premium assistance***

Governor Jerry Brown (D) vetoed legislation this week that sought to create guardrails for premium assistance provided by non-profit charitable organizations like PSI.

In his veto message, the governor sided with concerns expressed by PSI and other consumer and provider groups that the provisions in the bill (S.B. 1156) go “too far” because they would let health plans pick and choose which patients to cover by simply refusing third-party premium assistance for those with costlier conditions. He instead encouraged stakeholders to “find a more narrowly tailored solution that ensures patients’ access to coverage.”

The legislation was sparked by federal Department of Health and Human Services (HHS) claims 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 bill initially went beyond the guardrails 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 that would prevent 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, under the final bill (which is likely to resurface next session), third-party premium assistance would still have to (1) be provided 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 not be conditioned on the use of specific facility or health care provider.

If these conditions are not met, S.B. 1156 would have capped 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.

Despite the veto, insurers still are required 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 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 (see Update for Week of May 7<sup>th</sup>). That bill now has at least 175 bipartisan cosponsors.

#### District of Columbia

##### ***Marketplace insurers received double-digit premium increases despite individual mandate***

The Department of Insurance, Securities and Banking (DISB) released final approved premiums last week for DC Health Link, the health insurance Marketplace that the District created pursuant to the Affordable Care Act (ACA).

DICB downgraded rate increases for three of the four participating insurers that filed proposed premiums last June. The average individual plan will see premiums increase by an average of 13 percent, well above the national average of nearly four percent calculated earlier this month by Avalere Health (see Update for Week of September 10<sup>th</sup>).

DC Health Link will have the same four insurers as 2018 (Aetna, CareFirst BlueCross BlueShield, Kaiser Permanente and UnitedHealthcare). However, only CareFirst and Kaiser Permanente will offer individual coverage while the others will participate solely in the small group Marketplace. Premiums for Kaiser Permanente will increase by an average of 20 percent, while CareFirst received a 16.7 percent increase for its PPO option and 9.5 percent for HMO offerings.

The double-digit increases were needed despite the District enacting its own alternative to the individual mandate under the ACA, whose tax penalty has been repealed for 2019 (see Update for Week of September 10<sup>th</sup>). By contrast, both CareFirst and Kaiser (who are also the only two participating insurers in Maryland's Marketplace) will dramatically slash premiums for 2019 for Maryland consumers after that state sought to restore reinsurance payments for insurers instead of an individual mandate (see Update for Week of September 10<sup>th</sup>).

DC Health Link was one of only three Marketplaces (besides California and New York) that maintained the full 12-week open enrollment period for 2018 and will continue to do so next year (running from November 1<sup>st</sup> through January 31<sup>st</sup>).

##### ***New legislation would limit short-term health plans to three months***

Legislation introduced this week by City Council member Vincent Gray (D) would make the District of Columbia the latest jurisdiction to limit the use of short-term health plans that can evade key consumer protections in the Affordable Care Act (ACA).

The bill (B22-1001) would impose the same three-month limit on short-term coverage that the Obama Administration imposed following the implementation of the ACA and make them non-renewable (see Update for Week of June 20, 2016). However, final regulations under the Trump Administration (that became effective October 2<sup>nd</sup>) extends that limit to 364 days and allows them to be renewed for up to 36 months (see Update for Week of August 13<sup>th</sup>).

The final rule does allow states to regulate the sale of short-term plans on their own terms. California enacted legislation last week that outlaws short-term coverage entirely (see above) while several others including Colorado, Delaware, Hawaii, Maryland, Vermont, and Washington have already taken action put comparable limits on their use (see Update for Week of August 27<sup>th</sup>).

#### Montana

##### ***Governor convenes working group to draft legislation authorizing reinsurance payments to insurers***

Governor Steve Bullock (D) announced last week that he is convening a 13-person working group to draft legislation authorizing Montana to seek a federal waiver to create a reinsurance program.

The Republican-controlled legislature had passed authorizing legislation last year that would have allowed Montana to mitigate individual market rate hikes by creating a federal-state reinsurance program to compensate insurers for exceptional claims, similar to the ones the Trump Administration has approved for eight states (see Update for Week of August 27<sup>th</sup>). However, Governor Steven Bullock (D) vetoed the legislation (H.B. 652) because it gave Insurance Commissioner Matt Rosedale (R), an ardent ACA critic, the discretion to instead segregate consumers with costly pre-existing conditions into a high-risk pool (see Update for Weeks of May 29 and June 5, 2017).

The working group will use information from a recent Montana Healthcare Foundation study predicting that a reinsurance program would lower premium increases in Montana by roughly 10-30 percent, based on the experience in states like Maryland where premiums decreased by an average of 42 percent immediately after the reinsurance waiver was federally-approved (see Update for Week of September 10<sup>th</sup>).

Blue Cross and Blue Shield of Montana (the dominant carrier in the state) has already stated that a reinsurance pool is the company's top legislative priority for the 2019 session. However, it opposes current proposals to fund the state share of reinsurance costs via a 1-2 percent assessment on all insurers. BCBS already pays a 2.75 percent assessment but its only two individual market competitors (PacificSource and Montana Health CO-OP) do not. BCBS projects that extending that assessment to both insurers would raise \$12 million per year.

However, urgency to implement the reinsurance program may dissipate somewhat next year thanks to premium increases that are likely to average only around six percent (see Update for Week of June 25<sup>th</sup>). The highest average increase of 10.6 percent belongs to Montana Health CO-OP, one of only four remaining non-profit Consumer Operated and Oriented Plans (CO-OPs) created with ACA loans. Despite its financial struggles, Montana Health CO-OP has successfully enrolled more consumers (23,300) than BCBS (18,500 members) or PacificSource (12,700). PacificSource is seeking a 6.2 percent average rate hikes while BCBS will not increase premiums at all for 2019.

The insurers pointed out that increases likely would have been flat or reduced had the Trump Administration not eliminated the individual mandate tax penalty for 2019 or allowed for the proliferation of limited-benefit coverage that does not comply with the ACA (see Update for Week of May 28<sup>th</sup>).

#### North Dakota

#### ***Insurance Department to propose federal waivers for reinsurance program, non-ACA compliant health plans***

Insurance Commissioner Jon Godfread (R) released the findings last week of an actuarial study commissioned by the Department of Insurance, which recommended that North Dakota seek federal permission to create an "invisible" reinsurance program in order to mitigate premium increase in the individual market.

Seven states have already received State Innovation Waivers under Section 1332 of the Affordable Care Act (ACA) that allow them to create reinsurance programs with a combination of federal and state funds (see Update for Week of August 27<sup>th</sup>). The programs have resulted in dramatic reductions in average premium increases as insurers are able to receive retroactive compensation for incurring an exceptional amount of claims, similar to the reinsurance payments under the ACA that expired after 2016 (see Update for Week of September 10<sup>th</sup>).

The reinsurance model proposed by the Department would cover 75 percent of paid claims for cumulative subscriber costs of between \$200,000 and \$1 million per year. These amount would be more generous than in the other seven states with approved reinsurance waivers, but could be altered as needed by the Department. The state share would be funded by an assessment on insurers.



The Department predicts that creation of the reinsurance pool (which is called “invisible” because high-cost subscribers remain in the same risk pool with others), would reduce individual premiums by 10-20 percent for the 2020 plan year, while increasing individual market enrollment by one percent.

The study also recommended that the Department create a new reduced premium, higher cost-sharing “state-based plan option” for individual market consumers outside of the ACA Marketplace. However, unlike the non-ACA complaint state-based plans that the Trump Administration refused to allow in Idaho (see Update for Week of March 19<sup>th</sup>), the plans the Department would develop would still be required to offer all of the essential health benefits mandated by the ACA, as well as be offered to everyone regardless of health status (i.e. guaranteed issue) unless they have a coverage lapse of at least 63 days (the standard in place prior to the ACA). However, the state-based plans would allow credits for healthy behaviors or other health-related factors to be defined by the Department. This would theoretically give younger and healthier consumers a lower-cost option.

The study recommends that the Department draft legislation for the 2019 session that incorporates both options and which could be implemented for the 2020 plan year. It predicts that the two models would increase competition in the individual market, which currently only has three participating insurers for 2019 (in and out of the ACA Marketplace). While Noridian BCBS will increase average premiums by only about 2.3 percent in the Marketplace and 1.4 percent outside the Marketplace, Sanford Health Plan and Medica received a 21.5 percent and nearly 26 percent increase respectively for Marketplace plans and 7.6 percent and 23 percent outside the Marketplace.

#### Virginia

#### ***Medicaid agency moves forward on work requirements despite adverse court decision***

The Department of Medical Assistance Services (DMAS) has formally released its proposed Section 1115 demonstration waiver seeking approval from the federal Centers for Medicare and Medicaid Services (CMS) to impose work requirements on those made newly-eligible by the upcoming Medicaid expansion.

The work requirements were part of a compromise that broke a legislative stalemate over whether Virginia would finally participate in the ACA expansion. After lawmakers approved the expansion plan last spring, DMAS promptly submitted the state plan amendment to CMS that would add roughly 400,000 Virginians earning up to 138 percent of the federal poverty level (FPL) starting January 1<sup>st</sup> (see Update for Week of May 28<sup>th</sup>).

Under the Section 1115 waiver, Virginia would require that newly-eligible adults (age 19-65) prove they are spending at least 20 hours per month on “work-related activities” for the first three months of eligibility. That requirement would gradually increase up to 80 hours per month. Enrollees who fail to comply would have their coverage suspended.

Additionally, the waiver would impose first-time monthly premiums (on those subject to the work requirements) that would start at \$5 for those earning 100-125 percent of FPL and increase up to \$10 for those earning 126-138 percent of FPL. Enrollees that fail to comply after a three-month grace period would also have their coverage suspended.

DMAS will accept public comments through October 20<sup>th</sup> before submitting the waiver proposal to CMS.

Both DMAS and CMS state they are undeterred by a federal court ruling in June that invalidated CMS’ approval for work requirements in Kentucky (see Update for Week of June 25<sup>th</sup>). Three other states (Arkansas, Indiana, and New Hampshire) have already received federal approval and at least nine states have or are in the process of submitting federal waivers. However, California has acted to ban work requirements from their Medicaid program (see above).

DMAS officials also suggested that the Medicaid expansion could go forward as planned even if the work requirements are ultimately blocked by the courts. However, Delegate Scott Garrett (R), who chairs a health Appropriations subcommittee, insisted that Medicaid expansion was explicitly conditioned on the work requirements and could not proceed separately.