



## Health Reform Update –Week of June 9, 2014

### CONGRESS

#### ***Marketplaces are expanding insurers and provider networks (for those willing to pay more)***

The White House responded to House Republican criticism this week regarding limited competition and provider networks for several Marketplaces created under the Affordable Care Act (ACA) by highlighting that insurer participation is increasing next year in both the state and federal models. For example, New Hampshire will have five insurers instead of just one in 2014 (see Update for Week of June 2<sup>nd</sup>), Indiana will double from four to eight, Illinois will jump from six to ten (while the number of policies will triple to 504), Michigan will move from 13 to 18, and Washington will climb from eight to 12 (see Update for Weeks of April 28<sup>th</sup> and May 5<sup>th</sup>). Other states like Georgia, Kentucky, and Virginia are expecting at least one additional insurer.

They also pointed to a new study by McKinsey and Co. consultants, which found that the overwhelming majority of Marketplace insurers have expanded their provider networks for 2015.

The Centers for Medicare and Medicaid Services (CMS) took steps to require broader provider networks earlier this year following complaints that initial Marketplace insurers relied on extremely narrow provider networks to keep premiums affordable (see Update for Weeks of March 17<sup>th</sup> and 24<sup>th</sup>). The McKinsey study found that insurers have responded by expanding networks to the point where broad networks will now be available “to close to 90 percent of the addressable population.”

However, Marketplace insurers are making consumers pay 13-17 percent more on average for plans with these broader networks, while continuing to give 92 percent of consumers the choice to purchase lower cost plans with narrow networks. Nearly half of all Marketplace plans still offer limited networks, including nearly 70 percent of the lowest-tier plans (bronze and silver). The survey specifically found that nationwide “close to 70 percent of the lowest- price products are built around narrow, ultra-narrow, or tiered networks.”

Researchers found “no meaningful performance difference” between plans with broad and narrow exchange networks as it relates to federal outcome measures”. However, they did note that “broad networks have higher rates of academic medical center participation.”

#### ***Loss of House Majority Leader stalls action on health spending bills***

The unprecedented primary loss this week by a sitting House Majority Leader has indirectly caused two appropriations bills for Health and Human Services (HHS) and the Food and Drug Administration (FDA) to be halted or remain dormant.

The inaction increases the likelihood that neither will be enacted before the end of the September 30<sup>th</sup> federal fiscal year, requiring either a continuing spending resolution or another showdown over shutting down the government. The latter is viewed as unlikely during an election year.

After his primary loss, Rep. Eric Cantor (R-VA) immediately announced he would step down from his post as Majority Leader on July 31<sup>st</sup>. He is likely to be replaced by current Majority Whip Kevin McCarthy (R-CA), although Rep. Raul Labrador (R-ID) is challenging him as a more conservative alternative.



Cantor's loss was largely viewed as a formal end to the Republican's "repeal and replace" strategy for the ACA, which he championed. However, more conservative members of the House continued to insist on forcing "uncomfortable" votes on amendments that would impede or repeal certain ACA provisions, causing appropriations measures to be stalled for the time being.

### ***Lawmakers debate mixed results for non-profit cooperatives created by the ACA***

The chairman of the House Oversight Committee criticized Affordable Care Act (ACA) loans to incentivize the creation of non-profit insurance cooperatives after initial enrollment figures for 14 of the 23 new Consumer Operated and Oriented Plans (CO-OPs) came in far below expectations.

Chairman Darrell Issa (R-CA) contrasted the enrollment figures with the loan amounts for each CO-OP to point out that 11 CO-OPs spent "more than \$10,000 for each person enrolled", raising "serious questions about how these CO-OPs plan on staying solvent and that taxpayers will ever be repaid."

Democratic lawmakers pointed out that several CO-OPs vastly exceeded initial enrollment projections and garnered significant market share against dominant competitors. Three have also already made plans to expand into neighboring states for 2015. For example, Maine Community Health Options used a \$64.6 million loan to enroll more than 39,000 consumers as of May 1<sup>st</sup>, more than double its initial projection of 15,500 and roughly 80 percent of the all enrollment in Maine's Marketplace (see Update for Week of June 2<sup>nd</sup>). Common Ground in Wisconsin tripled initial projections with nearly 30,000 enrollees while CoOpportunity Health (which operates in Iowa and Nebraska) reached nearly 77,000 enrollees despite being only expected to sign-up 18,700.

### ***Physicians groups seeking extension/expansion of Medicaid primary care payment increase***

Several physician groups urged Senate Finance and House Energy and Commerce leaders this week to extend the temporary increase in Medicaid payments for primary care physicians that was provided by the Affordable Care Act (ACA).

The two-year payment bump set Medicaid primary care payments at Medicare levels for certain services but is set to expire December 31<sup>st</sup>. In order to receive the payments, physicians must have a specialty designation of family medicine, general internal medicine or pediatric medicine.

The American Academy of Family Physicians, American Academy of Pediatrics, America's Essential Hospitals, and Children's Hospital Association are among those groups seeking not only to extend those payments for another two years but expand them to also include OB-GYN physicians as well (noting that Medicaid programs in 34 states and the District of Columbia explicitly recognize OB-GYNs as primary-care providers.)

## **FEDERAL AGENCIES**

### ***Federal court blocks proposed rule extended 340B discounts to orphan drugs***

A federal court decision in favor of the Pharmaceutical Research and Manufacturers of America (PhRMA) is threatening to block the release of federal regulations extending drug discounts under the Section 340B program to orphan drugs (see Update for Week of September 30<sup>th</sup>).

Congress created the 340B program in 1992 to allow hospitals that care for low-income patients to obtain drugs at substantially reduced prices. The program requires that drug manufacturers participating in the Medicaid drug rebate program extend substantial discounts on drugs administered in the outpatient setting, including oral drugs that can be distributed through contract pharmacies and physician-administered drugs such as those used to treat cancer.



The 340B program has grown dramatically from 591 participating hospitals in 2005 to more than 16,500 covered entities by 2011, raising heightened scrutiny from regulators over whether program eligibility is too broad, the program is sustainable, and/or some participants are reaping improper windfalls by not passing savings onto consumers (see Update for Weeks of July 1 and 8, 2013)..

According to the Alliance for Integrity and Reform of 340B, drug purchases through the program will almost double, from \$6 billion in 2010 to \$13.4 billion by 2016. However, more than two-thirds of participating hospitals provide less charity care as a percent of patient costs than the national average for all hospitals, including for-profit hospitals which do not qualify for 340B under current eligibility criteria.

The Affordable Care Act (ACA) made several changes to the program, which included extending 340B discounts to orphan drugs used for non-orphan indications by rural and cancer hospitals (see Update for July 15-August 2, 2013). However, the ruling by the U.S. District Court for the District of Columbia held that the Health Resources and Services Administration (HRSA) that administers the program lacks the authority under the ACA to implement these provisions.

The Safety Net Hospitals for Pharmaceutical Access representing 340B providers opposed the injunction granted against HRSA's implementing regulations that are currently awaiting the final paperwork approval from the Office of Management and Budget before being published. If not overturned on appeal, the injunction likely will postpone the expected June release of the proposed regulations, which will provide "comprehensive 340B Drug Pricing Program requirements for participating covered entities and manufacturers."

Though it has yet to decide whether to appeal the decision, HRSA pledged to implement the provisions through interpretive guidance or other alternatives to formal rulemaking. However, these would not have the same force of law.

It is not clear if a separate proposed rule that would "establish the extent to which AIDS Drug Assistance Programs can collect rebates from manufacturers" will be impacted by the court decision. It is expected to be released by HRSA in December 2014.

The Community Oncology Alliance (COA) released their own report this week concluding that at least 120 hospitals with 340B pricing acquired one or more independent oncology practices between 2009 and 2012. Because the cost of cancer care delivered in hospitals is more expensive than in physician-owned practices, researchers estimated that Medicare paid \$23 million more and Medicare patients paid \$4 million more for cancer care than they would have if the practices remained independent.

### ***CMS announces new funding opportunity, rules for Marketplace navigators***

The Centers for Medicare & Medicaid Services (CMS) released \$60 million in additional grants last week to support navigators that facilitate enrollment in federally-facilitated and state partnership Marketplaces for 2014-2015. The grants are open to new and returning navigator applicants that apply by July 10<sup>th</sup>.

Final regulations published on May 27<sup>th</sup> by CMS also updated the standards that navigators must meet under the new grant awards (see Update for Week of June 2<sup>nd</sup>). This includes a requirement that navigators now maintain a physical presence in the Marketplace service area, so that face-to-face assistance can be provided to consumers, as well as weekly and monthly reports that must be submitted to CMS. However, this requirement does not apply to certified application counselors (CACs).

CMS will allow states to require background checks, fingerprinting, licensure, etc. for all navigator and non-navigator assisters. Even in states without these requirements, it will also encourage navigators to perform background checks for all staff that will be handling sensitive or personally identifiable



information. However, it will specifically not allow states to require that navigators or CACs maintain a physical presence in a state that has defaulted to the federally-facilitated Marketplace.

### ***Study finds Marketplace plans cost less than comparable outside plans***

A new study released last week by HealthPocket found that four of the nation's leading insurers found that the coverage they offered in the Marketplaces created by the Affordable Care Act (ACA) were significantly less costly than non-Marketplace plans even though coverage levels were similar.

The consumer research group compared premiums for bronze, silver and gold plans from Aetna, Assurant, Cigna and United Healthcare and concluded that on average their non-Marketplace plans cost 40 percent less. Researchers noted that the higher premiums for non-Marketplace plans could be in lieu of lower deductibles and coinsurance found inside the Marketplaces.

### ***Study shows Marketplace plans are moving high-cost drugs into specialty tiers***

A study funded by the Pharmaceutical Research and Manufacturers of America (PhRMA) concluded this week that Marketplace plans are leaving many consumers with serious illnesses without access to essential prescription drug therapies.

The analysis from the consulting firm Avalere Health examined the cost-sharing obligations that Marketplace plans are imposing on patients with cancer, HIV/AIDS, bipolar disorder, and autoimmune diseases such as rheumatoid arthritis and multiple sclerosis. It found that for seven of 19 classes of medicines, 39 percent of silver-level plans require patients pay at least 40 percent of the cost of their medications. In addition, 86 percent of all plans place all of the covered drugs for at least one class on the highest formulary tier.

The findings support a complaint filed by The AIDS Institute (TAI) and the National Health Law Program alleging that moving all or most drugs in a single class into the highest specialty tier violates the anti-discrimination provisions of the Affordable Care Act (see Update for Week of June 2<sup>nd</sup>). TAI pointed out this week that the Avalere study specifically showed that of the four classes of HIV drugs, 27-39 percent of the 123 Marketplace plans studied placed every single HIV drug (including generics) on their highest specialty tier.

PhRMA used the findings to focus blame for access problems arising from such prohibitive specialty tier coinsurance upon insurer practices and not the cost of the drugs.

### ***ACA tweaks proposed by AHIP include catastrophic plans, more network transparency***

Groups representing consumers and drug manufacturers remained wary this week of a proposal by America's Health Insurance Plans (AHIP) to broaden catastrophic coverage in Affordable Care Act (ACA) Marketplaces, though they largely supported AHIP's plan to provide consumers with more information about provider networks under Marketplace plans.

AHIP specifically proposes to create a catastrophic coverage level with lower premiums and fewer benefits than bronze-level plans that are currently the lowest tier available to all consumers. While the ACA did create a catastrophic coverage level, it currently is limited to consumers under age 30 and does not allow low-to-middle income consumers to use the premium subsidies available for other plan levels. As a result, less than two percent of Marketplace consumers selected this catastrophic option, even though the other ACA market reforms still apply (such as no lifetime caps).

However, Families USA and the National Health Council instead this week that allowing plans to offer coverage below the "already inadequate" bronze-level (that only covers an average of 60 percent of medical costs) would impose prohibitive out-of-pocket costs and be "harmful" to consumers.



The Pharmaceutical Research and Manufacturers of America (PhRMA) responded by pointing to an Avalere Health report they funded showing that out-of-pocket prescription drug costs for bronze and silver-level plans are currently overburdening “vulnerable patients” and the greater cost-sharing required by an even lower plan option would simply make it “harder for them to access the medicines they need” (see above).

By contrast, other parts of AHIP’s proposal were welcomed by drugmakers and consumer groups as they offered to provide more “accessible, understandable, and up-to-date information about which providers are in a network and timely notice to consumers when providers leave the network.” Disruptions of care that arose from unexpectedly narrow provider networks in Marketplace plans was a leading criticism of insurers during the 2014 open enrollment period and already led to new standards being imposed by the Obama Administration for 2015 (see Update for Week of March 17<sup>th</sup> and 24<sup>th</sup>).

### ***Kaiser survey says star ratings do not influence choice of Medicare Advantage or Part D plans***

A new study released this week by the Kaiser Family Foundation concludes that quality ratings given to Medicare Advantage (MA) and Part D plans (PDPs) do not factor into enrollees’ choice of plans.

According to the survey, enrollees focus on premiums, out-of-pocket costs, provider networks, access to prescription drugs, and name recognition when selecting a particular plan. Enrollees largely questioned the reliability of the star ratings assigned to these plans by the Centers for Medicare and Medicaid Services (CMS) and did not take them into account.

The star ratings dictated whether plans received bonus payments under the Affordable Care Act (ACA) demonstration that CMS recently curtailed in the face of criticism that too many plans were benefiting from these payments (see Update for Week of April 7<sup>th</sup>). On average, the 15 highest-rated MA plans were responsible for 180 percent of the program growth, with others have actually lost business. For PDPs, the 15 highest-rated plan cover 95 percent of all Part D enrollees.

Analysts point out that the greater level of benefits highly-rated plans could consequently offer indirectly influences beneficiary choice. However, the survey revealed that enrollees tended to view the ratings as reflecting only other enrollee experiences that did not necessarily mesh with their own needs.

### ***More than three million have enrolled in private health insurance exchanges***

A study released this week by Accenture found that more than three million Americans used private health insurance exchanges last year to enroll in employer-sponsored coverage or more than three times the level the consulting firm initially projected.

Accenture now estimates that this number will explode to roughly 40 million by 2018, exceeding the number of people projected to enroll in the health insurance Marketplaces created pursuant to the Affordable Care Act (ACA).

Researchers concluded that small and mid-size businesses with up to 1,000 employees were driving the enrollment spike, as the private exchanges help them stabilize benefit costs and shift more burden to employees. Roughly 25 percent of employees enrolling through private exchanges wound up selecting a plan that provide less coverage than their previous employer-sponsored plan, but also offered lower premiums.

### ***FDA finalizes guidance on expedited approval for breakthrough drug therapies***

The Food and Drug Administration (FDA) issued final guidance on May 29<sup>th</sup> detailing the process for expedited the approval of drug for serious health conditions.



The FDA has created four expedited programs (fast track designation, accelerated approval, priority review, and breakthrough therapy designation). The final guidance retains most of the draft proposal from last year but includes several changes in response to public comments about the breakthrough therapy program created as part of the 2012 user fee reauthorization (see Update for Week of June 25, 2012), which has already approved 48 of 186 requests. These revisions include provisions emphasizing that breakthrough status is merely “advisory” and does not guarantee ultimate FDA approval as well as details of the specific evidence needed to obtain breakthrough status.

The guidance also defines the general threshold criteria for all expedited programs, including how to determine what is meant by serious condition, unmet medical need and available therapy.

## STATES

### California

#### ***Anthem to seek only single-digit increases in Marketplace premiums***

Anthem Blue Cross insisted this week that it will not seek to increase its Covered California premiums by double-digits for the coming year after the age and medical costs for initial enrollees were in line with the insurer’s projections.

The Marketplace created pursuant to the Affordable Care Act (ACA) will soon start negotiating with individual insurers for 2015 premiums, as California is one of only five Marketplaces that elected the “active purchaser” model where the Marketplace can exclude participants based solely on cost (see Update for Week of May 27, 2013). Final rates will be published in late July.

Anthem garnered a roughly 30 percent market share in Covered California after the inaugural open enrollment period (see Update for Week of April 14<sup>th</sup>), outpacing both Blue Shield of California and Kaiser Permanente, which have declined to disclose their proposed premiums.

Anthem’s premium increase is slightly below those that have been revealed nationwide, which have mostly been in the low double-digit range experienced prior to the ACA (see below).

#### ***Budget deal funds ACA implementation but leaves most prior health-related cuts in place***

The legislature passed a budget compromise this week by the June 15<sup>th</sup> deadline that leaves most of the recession-era cuts to health programs in place despite legislative proposals to restore funding.

While the deal does continue all Affordable Care Act (ACA) implementation efforts (including the Medi-Cal expansion), funds HIV prevention programs, and includes new costly Hepatitis C drugs under the AIDS Drug Assistance Program (ADAP) formulary, the across-the-board ten percent reduction in Medi-Cal payment remains intact. If signed as expected by Governor Jerry Brown (D) before June 20<sup>th</sup>, the agreement will ensure that California will continue to have among the nation’s lowest Medicaid reimbursement levels for the coming fiscal year.

Even though roughly 70 percent of Medi-Cal enrollees have been transitioned into capitated managed care plans, roughly three million remaining in fee-for-service will remain subject to these rates, which were stayed until federal courts upheld them last year (see Update for Week of September 23<sup>rd</sup>). However, the Governor previously agreed to drop efforts to make the cuts retroactive to 2009 when they were first enacted (see Update for Week of January 6<sup>th</sup>).



Many lawmakers objected to the Governor's refusal to accept additional funds offered by the California Endowment to assist Medi-Cal enrollment and renewals, a grant included in last year's budget. The refusal means California will also forgo federal matching funds. However, lawmakers ultimately chose not to scuttle the compromise over this issue.

The budget deal also officially eliminates California's state high-risk pool for persons with pre-existing conditions.

### Louisiana

#### ***Governor signs legislation requiring insurers to accept certain premium assistance payments***

Governor Bobby Jindal (R) signed S.B. 403 into law last week, which formally requires health insurers to accept third-party premium assistance payments from funds or grants established by federal and state government programs.

The bill was in response to an effort by three Marketplace insurers in Louisiana to refuse federal Ryan White premium assistance payments for consumers with HIV/AIDS, effectively keeping those that could not afford the full premiums from entering the risk pool (see Update for Weeks of March 17<sup>th</sup> and 24<sup>th</sup>). The AIDS Institute, PSI, and other consumer groups had argued that allowing such exclusions would essentially permit insurers to circumvent the ban on pre-existing condition denials imposed by the Affordable Care Act (ACA).

In accordance with federal regulations issued last spring, S.B. 403 specifically cited Ryan White premium assistance payments as those that must be accepted starting August 1<sup>st</sup> (see Update for Weeks of March 17<sup>th</sup> and 24<sup>th</sup>). Initial versions of the legislation went a step beyond the federal regulations by requiring insurers accept premium assistance payments from all non-profit charities as well, but the final bill was amended to require them to accept such payments only from one designated charity (the American Kidney Fund).

S.B. 403 explicitly allows insurers to reject premium assistance payments made by health care providers.

### Minnesota

#### ***Uninsured rate drops to lowest in state history, second lowest nationwide***

The percentage of uninsured Minnesotans has dropped to the lowest level in state history, and the second-lowest level in the nation following the inaugural open enrollment period for the state-based Marketplace created by the Affordable Care Act (ACA).

The results of the study funded by the Robert Wood Johnson Foundation (RWJF) found that less than five percent of all Minnesotans are uninsured, trailing only the one percent uninsured rate for Massachusetts whose landmark health reforms in 2007 became the model for the ACA. Minnesota had a nine percent uninsured rate on September 30<sup>th</sup>, the day before the MNSure Marketplace opened.

However, researchers were careful to note Minnesota's decision to expand Medicaid under the ACA was the greatest contributor to the 44 percent drop in the state's uninsured rate. While nearly 237,000 MNSure applicants gained coverage, more than 200,000 were deemed eligible for Medicaid. Persistent glitches with the MNSure website prevented more than 36,000 Minnesotans from selecting private Marketplace coverage or only 42 percent of those eligible (see Update for Week of April 14<sup>th</sup>).

Another survey by the Urban Institute (also funded by RWJF) showed that the proportion of nonelderly adults in New Jersey who report being uninsured has decreased 38 percent - from 21.2 percent in September 2013 to 13.2 percent in March of 2014 due to an estimated gain in insurance coverage by more than 430,000 people. However, these results were based on figures only through



March 6<sup>th</sup> and do not reflect the late surge in enrollment nationwide (see Update for Week of April 7<sup>th</sup>). Therefore, researchers acknowledge that final results are likely to place New Jersey at its lowest level of uninsured since 1990.

New Jersey is one of the few states where Obama Administration data shows that enrollment in private Marketplace plans exceeded Medicaid enrollment during the inaugural open enrollment period (161, 775 compared to roughly 98,000). However, it notes the Medicaid numbers are lower for New Jersey than other states because it was also one of the few states that started expanding Medicaid before January 1, 2014.

New Jersey enrolled only about 26 percent of those eligible for private Marketplace plans. While this figure was below the national average (or the nation-leading 70 percent in Vermont) it was roughly consistent with the proportion of the eligible population enrolled by neighboring states of New York and Pennsylvania.

#### Texas

#### ***Texas receives federal approval to shift dual eligibles into managed care***

Texas became the 12th state last week to gain federal approval to move those eligible for both Medicare and Medicaid into capitated managed care plans.

The demonstration projected created pursuant to the Affordable Care Act (ACA) will start on March 1, 2015 and continue through 2018 in six of the most populous counties. Roughly 168,000 of the 400,000 dual eligibles in Texas will receive their care under a single health plan instead of Medicare paying first and Medicaid covering their cost-sharing and other expenses.

The Health and Human Services Commission (HHSC) projects that the demonstration will reduce federal and state costs by 1.25 percent next year and 5.5 percent by 2018.

Although the dual eligible demonstration drew initial interest from more than half the states, many have dropped out due to concerns about access and quality of care. However, several of the 12 approved states are headed by Republican governors that have been staunchly opposed to most other provisions of the ACA (see Update for Week of March 31<sup>st</sup>).

#### Vermont

#### ***Vermont hires outside consultant to fix glitch-plagued Marketplace***

Vermont became the latest state this week to hire outside help to resolve ongoing software failures with the health insurance Marketplace it tried to create pursuant to the Affordable Care Act (ACA).

Of the 15 states (including the District of Columbia) that elected to operate their own state-based Marketplace (SBM), five have been unable to fix glitches that greatly depressed initial enrollment. Vermont joins Maryland and Massachusetts in electing to bring in technology from another state, while Nevada and Oregon have decided to temporarily default to the federal model (see Update for Week of June 2<sup>nd</sup>).

As with Massachusetts, Vermont relied on CGI Federal to build the online web portal for the Marketplace (see Update for Week of January 6<sup>th</sup>). CGI is the same contractor responsible for the flawed rollout of the web portal for the federally-facilitated Marketplaces (FFM).

After months of working with CGI to correct initial failures, Vermont Health Connect officials have finally signed a six-month \$5.69 million contract with Minnesota health technology firm OptumInsight Inc. to correct flaws that CGI has been unable to address. However, CGI will continue to perform contract functions under a revised schedule, despite being assessed penalties for non-performance.





Among the problems that CGI has been unable to fix is the inability of consumers to modify applications once they are submitted. Governor Peter Shumlin (D) also had to issue an order allowing small businesses to purchase coverage directly from the two insurers in Vermont Health Connect after CGI was unable to make the small business Marketplace functional (see Update for Week of January 13<sup>th</sup>).

OptumInsight filled a similar support role in helping CGI rebuild the FFM web portal.

#### Virginia

#### ***Republicans use new Senate control to block any Medicaid expansion***

Senate Republicans used their new majority to push through a two-year budget this week that explicitly prohibits any expansion of Medicaid without the approval of the full General Assembly.

Debate over the Medicaid expansion had resulted in a three-month stalemate as Democratic leaders in the Senate insisted that it be included a part of the budget. The impasse threatened to shut down the government after the June 30<sup>th</sup> fiscal year end if an agreement was not reached.

However, Senate Republicans were able to procure the controversial resignation of Senator Philip Puckett (D) in exchange for certain concessions in a move that gave them control of the Senate and ability to block the inclusion of any Medicaid expansion approved by Governor Terry McAuliffe (D) or the legislative Medicaid commission created by his Republican predecessor (see Update for Week of June 2<sup>nd</sup>).

A Medicaid expansion alternative based on the “private sector” model that the Obama Administration already approved for Arkansas, Iowa, and Michigan had the backing of former Governor Bob McDonnell (R) and several key Republicans including Senators John Watkins and Emmet Hanger, but only if certain pre-conditions were met by the federal government, including allowing an expansion of Medicaid managed care in Virginia.

However, House Republican leaders dug in to oppose Medicaid expansion once Governor McAuliffe was elected (see Update for Week of November 11<sup>th</sup>). The prohibition in the state budget effectively undoes the compromise reached last year by Governor McDonnell in creating the Commission, forcing Governor McAuliffe to now contemplate pursuing some form of expansion through executive order. It is not yet clear if Governor McAuliffe will even sign the budget bill with the expansion prohibition included.

#### Washington

#### ***New Marketplace premiums are lowest for insurers with least market share***

A new analysis from Avalere Health found this week that proposed 2015 rate hikes for insurers participating in the Affordable Care Act (ACA) Marketplace for Washington were lowest among carriers that held the smallest market share in 2014.

Based on its review of 2015 rate filings, the insurer that captured only one percent of the 2014 Marketplace (Molina) proposed a seven percent increase, while other low enrollment carriers like Kaiser Permanente and BridgeSpan Health each sought average increases of less than two percent. By contrast, Centene and Group Health Cooperative (which each gained 16-17 percent of the Marketplace) proposed the largest average increase of over 11 percent while the dominant carrier (Premera Blue Cross with 46 percent) proposed an eight percent hike.



Avalere stressed that the findings are consistent with a “vibrant” and competitive insurance market like Washington, where smaller carriers strive to be competitive by pricing products below larger insurers.

For the 2015 open enrollment period, Centene currently has both the lowest and second-lowest cost silver plans in four of the state’s five regions and maintains the lowest average silver plan premium. BridgeSpan Health and Molina are expected to improve their silver-plan premium positioning, while Moda Health Plan is the only new market entrant to reach the top five in terms of silver-plan premium competitiveness. With nearly two-thirds of Marketplace enrollees choosing silver plans nationwide in 2014, competitive silver products are likely to be critical for the 2015 market.

Health care experts Henry Aaron of the Brookings Institution and former Centers for Medicare and Medicaid Services (CMS) Administrator Gail Wilensky told a health reform conference last month that they do not expect Marketplace insurers to seek huge premium increases as they would drive younger and healthier consumers out of their risk pools and raise overall costs. Premium increases sought thus far have largely been in the low double-digit range experienced prior to the ACA and projected by most market analysts (see Update for Week of June 2<sup>nd</sup>).