



Health Reform Update – Weeks of October 20 and 27, 2014

CONGRESS

Potential Republican control of Senate may not significantly alter ACA implementation

With polls showing that Republicans have better than a 50 percent chance of gaining control of the Senate during the mid-term elections next week, party leaders are openly strategizing on additional methods to further impede or obstruct implementation of the Affordable Care Act (ACA).

Retirements of Democratic stalwarts in states like Iowa, Montana, and West Virginia have paved the way for Republicans to win back the Senate by prevailing mostly in states that already tilt conservative. They need a net gain only six seats to gain a bare majority and are widely expected to pick-up at least four in Louisiana, Montana, South Dakota and West Virginia. However, with polls showing very tight races in states like Alaska, Arkansas, Colorado, Georgia, Iowa, Kansas, Kentucky, and North Carolina (five of which are seats currently held by Democrats), the final outcome could remain in doubt for weeks or months due to mandatory recounts and runoffs.

Republican control will ultimately be determined by voter turnout, which is traditionally low in midterm elections. The party not in the White House typically gains seats during midterms and that trend is expected to hold this year for both the House and Senate.

Should Republicans win the Senate, the odds that they will secure the 60-seat advantage needed to break a Senate filibuster are extremely unlikely, meaning Republicans will remain unable to pass any anti-ACA measure without either significant Democratic support. However, they could rely on budget reconciliation rules to pass revenue measures with only a bare majority, a process used by Democrats to get key provisions of the ACA through the Senate after they lost their 60-seat majority in 2010.

Reconciliation could theoretically be used to pass a number of long-sought Republican measures such as ending ACA subsidies to federally-facilitated Marketplaces (see below), repealing the individual and employer mandate assessments, blocking the controversial Medicare cost-cutting board, limiting reinsurance payments to insurers with exceptionally costly claims (see Update for Week of March 10th), and eliminating annual fees on insurers and drug and device makers. A likely veto from President Obama would stand in the way of enacting any of these measures, although repeals of the cost-cutting board and device tax may have enough bipartisan support to pressure the President to sign them.

Republican control of the Senate would most likely increase the number of investigations, subpoenas, and hearings over ACA implementation efforts and set the stage for the Presidential election in 2016 that could give Republicans the ability to follow-through on repealing the full ACA law. However, polls show that a majority of voters do not favor a full repeal, making it politically problematic for Republicans as more Americans gain health insurance coverage through the ACA.

In the short term, Republican control would likely stall action until January on current measures to permanently fix the flawed Medicare physician payment formula (see Update for Week of March 10th) and reauthorize the Children's Health Insurance Program.

Medicaid directors urge Congress to take action on specialty drug costs

The National Association of Medicaid Directors (NAMD) urged both Republican and Democratic leaders for four key Congressional committees this week to come up with an "immediate federal solution" that will reduce the high costs of specialty drugs, which are limiting access for Medicaid enrollees.



In a lengthy letter, the Medicaid directors cited two recently-approved “cures” for Hepatitis C including Sovaldi, whose \$1,000 per pill price tag tripled annual prescription drug spending in several states by just the first quarter of 2014. They note that at least 22 states have already implemented measures to limit access to Sovaldi to all but those most in need (see Update for Weeks of October 6th and 13th) and pushed members of Congress to consider similar measures despite the price controls or rationing being a “politically volatile topic.”

The letter outlined a series of options for Congress to consider, including (a) direct price controls, (b) increasing the federal matching rate for high-cost drugs, (c) creating a program similar to Section 304B (see below) that mandates discount prices for state health programs (especially for drugs impacting a certain percentage of Medicaid enrollees), (d) establishing a federal reinsurance program that would compensate states for exceptional drug costs, (d) allowing Medicaid to exclude products not found to be cost-effective by researchers, or (e) developing a federal program to help finance the provision of high-cost drugs similar to the AIDS Drug Assistance Programs.

The directors acknowledged that Congress is likely to incur “substantial pushback” from the industry for considering measures such as direct price controls or mandatory discounts and the Pharmaceutical Research and Manufacturers of America immediately denounced their letter, claiming that prescription drug spending continues to account for roughly the same ten percent of all health care spending that it did in 1960. However, the directors insisted that Congress has to be “realistic about the choices and trade-offs involved when taxpayer dollars are used to fund high-cost services and products.”

FEDERAL AGENCIES

HRSA orders 50 drugmakers to comply with interpretive rule requiring orphan drug discounts

The Health Resources and Services Administration (HRSA) directed more than 50 drug manufacturers this week to issue refunds to safety net hospitals participating in the Section 340B drug discount program.

The manufacturers were cited for failing to provide mandatory 340B discounts for orphan drugs when used for non-orphan indications. They had refused to comply with HRSA’s recent “interpretive” rule that failed to extend the Affordable Care Act’s orphan drug exemption for these types of uses.

The controversial rulemaking was intended to circumvent a federal court injunction issued earlier this year, which stated that HRSA lacked the authority under the ACA to issue formal regulations on the exemption. The Pharmaceutical Research and Manufacturers of America (PhRMA) recently filed a second lawsuit challenging HRSA’s interpretation (see Update for Weeks of October 6th and 13th). However, HRSA continues to insist that the court did not invalidate its interpretation of the ACA statute or prevent it from issuing “interpretive” rules (see Update for Week of July 21st).

According to the Safety Net Hospitals for Pharmaceutical Access and the National Rural Health Association, who supported HRSA’s rulemaking, most drugmakers are disregarding HRSA’s interpretation until the legal challenges are resolved.

Social Security disability increase fails to break two percent for third consecutive year

The Social Security Administration (SSA) announced this week that benefit payments for more than 70 million Americans (including eight million receiving disability benefits) will rise by only 1.7 percent for 2015 as the national rate of inflation remains low.



The cost-of-living adjustment (COLA) is slightly more than the 1.5 percent increase for 2014 and well below the four percent average increase since 1975. It marks the third consecutive year that benefits will increase by less than two percent.

COLAs are increased annually based on the Consumer Price Index (CPI) to ensure that Social Security retirement and disability benefits are not eroded by inflation. In years in which inflation is nominal (such as 2010 and 2011), recipients receive no COLA increase. Since 1975, Social Security increases have averaged about four percent.

The National Committee to Preserve Social Security and Medicare criticized the 1.7 percent increase, noting that it will amount to only about \$20 per month for the average recipient and is far below the 3.8 percent average increase for 2015 in health care premiums for federal employees and retirees.

The Centers for Medicare and Medicaid Services announced last week that the continued slowdown in the growth of health care costs will leave Medicare Part B premiums largely unchanged for the third consecutive year (see Update for Weeks of October 6th and 13th).

CMS will allow insurers to exit the federal Marketplace if premium subsidies are invalidated

The Centers for Medicare and Medicaid Services (CMS) sent notice in mid-October to insurers participating in the federally-facilitated marketplace (FFM) that they will be allowed to terminate their contracts if premium tax credits provided by the Affordable Care Act (ACA) are invalidated by the U.S. Supreme Court.

According to *Inside Health Policy*, the “out” clauses were inserted at the insistence of insurers, who had to sign contracts for the 2015 open enrollment period by October 22nd. Contrary appellate rulings last summer created uncertainty over whether the tax credits would ultimately be eliminated for FFM consumers, although one adverse decision from a three-judge panel is expected to be overturned by the full appellate court in December (see Update for Weeks of August 25th and September 1st).

At least four legal challenges to the subsidies have been filed nationwide by conservative groups, insisting that the text of the ACA statute permits the subsidies to be provided only to consumers in state-based Marketplaces. The U.S. Supreme Court is likely to intervene only if a split in opinions remains after all appellate challenges have been resolved (see Update for Week of September 29th).

CMS proposes payment methodology for Basic Health Plan option created by ACA

The Centers for Medicare and Medicaid Services (CMS) issued a proposed notice last week outlining its plan to reimburse states under the Basic Health Plan (BHP) option created by the Affordable Care Act (ACA).

CMS intends to issue a final notice in February 2015 for the BHP option, which was designed to let states offer lower-cost coverage options for those earning 133-200 percent of the poverty that do not qualify for Medicaid even in expansion states and would still have trouble affording any level of Marketplace plan despite ACA premium and cost-sharing subsidies. However, CMS delayed the BHP until 2015 in order to focus on Marketplace implementation (see Update for Week of September 23, 2013) after very few states expressed interest, mostly due to fears that the BHP would siphon away enrollment needed to keep their Marketplaces financially viable (see Update for Week of March 25, 2013).

Final rules issued last spring provides states with additional federal matching funds should they exercise the BHP option. BHP states will receive 95 percent of the cost that the federal government would have incurred had BHP beneficiaries instead opted to use ACA subsidies to purchase Marketplace coverage. The rules also require that state BHP plans comply with the minimum essential health benefits packages required by the ACA, but they can provide additional benefits at their discretion.



CMS' latest notice clarifies that it will use the same payment methodology in 2016 that it already outlined for BHP states in 2015 (see Update for Week of February 10th). The methodology arrives at a total federal BHP payment based on multiple and distinct "rate cells" in each state that account for age range, geographic variations, type of coverage, household size, and income. However, CMS will allow states to propose separate payment models in 2016 that factor in assumed health differences between BHP and Marketplace enrollees. State proposals must be approved by December 31st.

Public comments on the proposed notice are expected to be due by November 23rd.

Consumer advocates upset that CMS again delays ACA transparency provisions for insurers

The Centers for Medicare and Medicaid Services (CMS) announced this week that it will not enforce insurer transparency provisions of the Affordable Care Act (ACA) until further guidance is released.

The agency had previously delayed enforcement until qualified health plan (QHP) issuers in the federally-facilitated Marketplace (FFM) had compiled a year's worth of claims data, despite the urging of consumer advocates to immediately move forward. The provisions at issue require QHPs and non-grandfathered group and individual plans to report data on enrollment, claims denials, out-of-network payments, and cost-sharing designs to both CMS and state insurance commissioners.

The rationale for the continued delay is unclear. The National Association of Insurance Commissioners (NAIC) insists that the data is urgently needed to conduct Marketplace analyses, such as the number of plans relying on specialty tier coinsurance that requires consumers to pay a high percentage of the cost of specialty medications. However, an NAIC consumer representative indicated this week that NAIC is reluctant to proceed without a uniform reporting and data collection system by CMS, because it does not want several different methods being used by various states.

The latest delay angered consumer advocates, as the ACA had required the transparency provisions to begin for non-Marketplace plans (that were not grandfathered) six months after the law was enacted (compared to the start of 2014 for Marketplace plans). CMS did not specify a timeline for the forthcoming guidance other than to say that it would not apply to non-Marketplace plans before it is in effect for Marketplace plans.

CMS to permanently extend higher matching rate for Medicaid eligibility systems

The Centers for Medicare and Medicaid Services (CMS) announced this week that it will permanently extend the 90 percent matching rate for states to upgrade their computerized Medicaid enrollment and eligibility systems. The permanent extension will be codified in future rulemaking, according to Deputy Administrator Cindy Mann.

The 90 percent matching rate was made available through 2011 rulemaking that also increased the federal match for costs to maintain the systems from 50 to 75 percent. That rule had scheduled the matching rate for upgrades to return to 50 percent on January 1, 2016.

Every state has taken advantage of the matching rate, including Tennessee which CMS cited for still being unable to implement their new system on time, resulting in the nation's largest backlog of Medicaid applications (see below).

In order to qualify for the permanent extension, states will have to meet updated criteria to prove they have completed the upgrades needed to incorporate the new Modified Adjusted Gross Income standard required by the Affordable Care Act.



Kaiser poll shows most uninsured unaware of Marketplaces or open enrollment

The most recent tracking poll from the Kaiser Family Foundation found that nearly two-thirds of the 1,500 uninsured adults surveyed know “only a little” or “nothing at all” about the new health insurance Marketplaces created pursuant to the Affordable Care Act (ACA), while 90 percent were unaware that open enrollment starts November 15th.

Kaiser acknowledged that the results mirror those it found before the inaugural open enrollment period last fall. However, researchers were surprised that extensive media coverage and outreach efforts by Marketplace personnel have done so little to raise awareness among the uninsured.

STATES

Soft launch begins for federal SHOP Marketplace in five states

Small businesses in Delaware, Illinois, Missouri, New Jersey, and Ohio received early access this week to the federally-facilitated version of the Small Business Health Options Program (SHOP).

This so-called “soft launch” is an effort by the Centers for Medicare and Medicaid Services (CMS) to identify and correct any of the technological glitches that plagued the rollout of the federally-facilitated Marketplace (FFM) for individual plans last fall (see Update for Week of November 11th). Small businesses in these five states can now create accounts, select brokers, verify eligibility, and upload a roster of workers. However, they still must wait until full online functionality starts with the open enrollment period on November 15th before they can shop for plans, compare prices, and enroll (see Update for Weeks of August 25th and September 1st).

The federally-facilitated SHOP (FF-SHOP) has already undergone a series of delays, including a one-year postponement of the start date. It will be operated in 32 states that have elected not to create their own version (see Update for November 18th – December 6th). However, CMS has already allowed 18 of the 32 FF-SHOP states to temporarily remain exempt from the employee choice requirement under the ACA (see Update for Week of June 2nd). These mostly conservative-leaning states can offer employees only one plan until at least 2016 (see Update for Week of March 3rd).

In the 15 states (and District of Columbia) that elected to start operating their own SHOP for the 2014 plan year, only two percent of eligible businesses have shopped for plans and even fewer have actually purchased coverage. The Urban Institute attributes the severely low rate of participation to confusion among small businesses about whether their SHOP was delayed until 2015 (see Update for Weeks of August 25th and September 1st).

One of those states, Washington, announced this week that its SHOP now offers small employers a choice of 23 plan options statewide. (In 2014, Kaiser Health Plan of the Northwest offered coverage in only two counties). Maryland, Mississippi, and Oregon are three additional states that plan to create their own SHOP Marketplaces for the 2015 plan year.

Unlike the individual Marketplace, SHOPS have no open enrollment so consumers can sign-up year round.

Democrats expect electoral gains among governorships, but not state legislatures

Regardless of whether Republicans take control of the U.S. Senate (see above), election results at the state level are likely to have a more tangible and immediate impact upon continued implementation of the Affordable Care Act (ACA).



According to the National Conference of State Legislatures, the party holding the White House has lost an average of 5.6 percent of all state legislative seats in midterm elections since 1900. If that trend holds, Republican control of legislative chambers will further expand from the 57 they currently hold (compared to only 41 for Democrats). Republicans also control both chambers in 27 states (compared to only 19 for Democrats).

Given this trend and current polling, governorships appear to be the best chance for any Democratic gains. Republicans must defend 23 of 36 governorships that are to be decided next week, and Republican incumbents in Florida, Georgia, Kansas, Maine, Michigan and Wisconsin are all locked in extremely tight races, while Pennsylvania Governor Tom Corbett (R) is trailing badly. Only two of these states (Michigan and Pennsylvania) have expanded Medicaid while all six refused to create their own ACA Marketplace.

In a state like Maine with a legislature under Democratic control, a change in governorship could lead directly to that state expanding Medicaid under the ACA. However, it remains to be seen what impact a Democratic governor can have on ACA progress in resistant states like Florida where legislatures will remain under Republican control. For example, former Florida Governor Charlie Crist (D) has pledged to expand Medicaid and restore rate review via executive order if return to the governorship. Yet newly-elected Virginia Governor Terry McAuliffe (D) was unable to follow through on a similar pledge last year despite Democratic-control of the Senate (see Update for Week of September 8th).

Six-state survey affirms that Marketplace premiums are being dictated by competition

Results from The Commonwealth Fund survey of approved Marketplace premiums for six states found that while premiums will fall on average in Colorado in Connecticut, they will increase significantly in Minnesota and Vermont and slightly in Maryland and Washington.

Researchers attributed the eight percent average decline in Colorado and one percent average decrease in Connecticut to the greater number of competitors entering those Marketplaces. For example, the number of plan options in Connecticut will double in 2015 due to the entrance of UnitedHealthcare.

Consistent with this trend, average premiums increased most precipitously from 2014-2015 in Marketplaces that have few participating insurers (see Update for Weeks of October 6th and 13th). The Commonwealth Fund found that Minnesota, which saw its largest participating insurer exit, will see average premiums increase by a whopping 19 percent—although these figures are disputed by the Department of Commerce, which insists the average increase will only be 4.5 percent, allowing the state to once again have the nation's lowest Marketplace premiums (see Update for Week of September 29th). Vermont, which still has only two participating Marketplace insurers, will see roughly a nine percent average increase, consistent with state-released figures (see Update for Week of September 8th).

Maryland and Washington, which both saw increased Marketplace competition, will see very modest average increases of only 0.4 percent and three percent respectively.

The results mesh with Administration and Kaiser Family Foundation reports showing Marketplace premiums are largely influenced by the number of competing insurers. Kaiser specifically estimated that premiums for the second lowest-cost silver plan will decline by roughly four percent for each additional insurer that enters the Marketplace (see Update for Weeks of August 25th and September 1st).

However, similar patterns do not necessarily show up in the cost-sharing levels set by Marketplace plans. Average deductibles, copayments, and out-of-pocket limits actually increased slightly or remained largely the same in Colorado, while average deductibles and copayments fell by 6-10 percent in Minnesota.



Average deductibles fell nearly nine percent in Connecticut, despite increases in copayments and out-of-pocket limits. Vermont also saw cost-sharing increases across the board although the state had previously reduced standard cost-sharing levels far below other states (the average deductible is only \$1,770 for 2015 compared to \$3,476 for Colorado).

Alabama

New competition from UnitedHealthcare is keeping 2015 premiums relatively flat

The Kaiser Family Foundation released an analysis this week of 2015 Marketplace premiums for three metropolitan areas in Alabama that showed little change from 2014.

Alabama's average Marketplace premiums were much higher than the national average during the inaugural open enrollment period due to limited competition. As with neighboring Mississippi, a dominant insurer (Blue Cross and Blue Shield of Alabama) was the only carrier offering Marketplace plans statewide and in 64 of the state's 67 counties it had no competition from other insurers. Only one other carrier (Humana) competed with Blue Cross and Blue Shield in the three largest counties.

According to Kaiser, the entrance of United Healthcare has had a dramatic effect as premiums in those counties will increase only slightly or in some cases even decline, contrary to the rate spikes many analysts projected. For example, the lowest cost silver-level plan for a 40 year old in the largest metro area of Birmingham (offered by Humana) will climb only three percent to \$262 per month, thanks largely due to UnitedHealthcare offering a silver-level plan at nearly the same price. By contrast, Blue Cross and Blue Shield is hiking rates for the lowest-cost silver plan offered to the same 40 year old by nine percent.

In the Huntsville area, United Healthcare priced its lowest silver plan at \$254 per month, which was only a one percent increase from the lowest silver premium for 2014. Humana matched that price.

The lowest silver premiums in the Mobile area will actually fall by two percent compared to 2014 (and fall by three percent for the second lowest cost silver plan), as UnitedHealthcare undercut previous premiums offered by Humana.

The figures are a supplement to Kaiser's analysis of 15 cities plus Washington, DC last month showing that Marketplace premiums for the second lowest cost silver plan will fall next year by less than one percent on average, as most regions are expecting an increase in competition (see Update for Weeks of August 25th and September 1st). That study concluded that premiums for the second lowest-cost silver plan are expected to fall by four percent for each additional insurer that enters the Marketplace.

Both Kaiser and Families USA noted that rate increases in Alabama are particularly difficult to monitor because the state does not release data to the public in a manner that is easily accessible to most consumers.

California

Insurance Commissioner denounces Anthem's small group rate hike as "excessive"

Insurance Commissioner David Jones (D) publicly declared this week that the 9.8 percent rate hike that Anthem Blue Cross put into effect for small group consumers on October 1st was "excessive and unreasonable", largely because it relied on overinflated projections for prescription drug costs and understated its profits.

Commissioner Jones had recommended that Anthem increase small group premiums by no more than 2.1 percent, citing an "unwarranted accounting maneuver" that moved certain profits into reserves. However, the insurer insisted that it lost \$85 million last year in the small group market and could not sustain similar losses in 2015.



Both as Assemblyman and Commissioner, Jones has repeatedly sought to expand the authority of the office to reject and modify excessive rate hikes, consistent with the authority given to his office over property and automobile rates and more than 30 other state insurance commissioners (see Update for Week of August 29, 2011). He worked with Consumer Watchdog to place a voter referendum on next week's ballot that would give him that authority. Although an insurer-funded media blitz appears to have diminished support for Proposition 45, the most recent poll results released this week by Stanford University showed the measure appears to be backed by a majority of likely voters (42 percent compared to 29 percent opposed). However, an earlier poll by the Public Policy Institute of California found that 46 percent did not support Proposition 45.

Absent that authority, Jones has frequently tried to use the provisions in the ACA requiring insurers to publicly justify any double-digit rate hike to shame or "jawbone" insurers into downgrading rate hikes. According to Consumer Watchdog, his department deemed roughly \$250 million in premium increases as "unreasonable" over a 15-month period ending in November 2013 (see Update for Weeks of June 30th and July 7th).

Michigan

Roughly 60 percent of Medicaid expansion enrollees are under age 35

Demographic data on early enrollees in the "private sector" Medicaid expansion alternative enacted by Michigan last April shows that roughly 60 percent are less than age 35.

Michigan was one of only five Republican-controlled states (including Arizona, North Dakota, Ohio, and Pennsylvania) that agreed to participate in the expansion under the Affordable Care Act (ACA). The program has proven to be more popular than expected, with enrollment passing its first-year projection of 300,000 enrollees in just over three months (see Update for Week of July 14th). By July 15th, it had already enrolled more than five percent of the entire population of Wayne County (which includes Detroit and surrounding suburbs).

Governor Rick Snyder (R) credits low wait times for the program's popularity, noting that most have been able to apply in-person and receive an eligibility determination within 30 minutes (see Update for Week of June 23rd). According to a study published this week in the *New England Journal of Medicine*, increased staffing for call centers has reduced waiting time to a mere three minutes.

Only five states including Michigan have received federal waivers allowing them to use ACA matching funds to instead purchase private Marketplace or Medicaid managed care coverage for the newly-eligible population (those earning up to 138 percent of the federal poverty level). However, Michigan was also allowed to increase cost-sharing for higher-income enrollees and incorporate health savings accounts (similar to waiver proposed by Indiana). Only 16 percent of initial Healthy Michigan enrollees have been under 100 percent of poverty and exempt from any cost-sharing.

Even though the majority of enrollees are under age 35 (including 42 percent that are aged 19-34), Healthy Michigan has actually enrolled a higher rate of adults age 45-54 years than traditional Medicaid.

More than 20 percent of new enrollees were transferred from existing categories of Medicaid coverage that provided limited benefits to programs for specific sub-groups of adults, such as the Adult Benefit Waiver Program for those with incomes up to 35 percent of the poverty.

New Hampshire

Dominant Marketplace carrier will not increase average premiums for 2015

Anthem Blue Cross and Blue Shield of New Hampshire announced this week that most of its consumers in the state partnership Marketplace (SPM) will not see any premium increases for 2015.



Anthem was the only carrier participating in the inaugural open enrollment period for the Marketplace, resulting in premiums that already well above the national average. Although some consumers could see small increases or decreases next year depending on their age and/or tobacco use, the insurer insisted that average premiums would remain flat for next year.

Anthem's silver-level policies are expected to again cost an average of \$360 per month. It will offer ten plans for individuals and families (and another three plans for the small group Marketplace).

Four competitors will join Anthem in the individual Marketplace for 2015, including two non-profit insurance cooperatives created with loans provided by the Affordable Care Act (ACA) (see Update for Week of June 2nd). One of these cooperatives, Maine Community Health Options, garnered 80 percent of Maine Marketplace consumers last year, where it competed only with Anthem (see Update for Week of February 24th).

Maine Community Health Options announced that their premiums for both Maine and New Hampshire will remain largely the same as 2014, costing a 25 year old consumer an average of \$204 per month for the lowest bronze-level plan up to an average of \$306 for gold-level coverage. For a 50 year old, premiums would range from an average of \$364 for bronze coverage and \$545 for gold. However, it will only offer plans in five New Hampshire counties next year (see update for Week of June 2nd).

More than 40 plan options are expected to be available to individual Marketplace consumers (up from only 11 last year), while each New Hampshire hospital will be available in at least three of the provider networks. Anthem faced broad criticism from lawmakers and stakeholders last year for excluding ten of the state's 26 hospitals from their Marketplace networks (see Update for Week of September 16, 2013).

North Carolina

Dominant Marketplace carrier hikes average premiums by double digits

North Carolina's largest health insurer announced this week that Marketplace consumers will see premiums for individual policies rise by more than 13 percent on average.

Blue Cross and Blue Shield (BCBS) of North Carolina will not start sending premium notices to individual consumers until next week. However, it provided examples showing that a 45-year old male in the Raleigh area can expect premiums for a silver-level plan to rise about 15 percent (or \$57) in 2015 to \$421 per month (before subsidies).

Premium increases for ACA-deficient or "transitional" plans offered by BCBS that remain exempt from the ACA through 2016 (see Update for Week of March 3rd) will rise even more (13-19 percent on average). In the example above, the same individual would pay \$278 (a 16.3 percent increase).

BCBS blamed the double-digit rate hikes on an initial risk pool that was older and sicker than projected, as well as the rising cost of specialty drugs like Sovaldi and Harvoni. However, critics were quick to point out that BCBS faces little competition in the federally-facilitated Marketplace operated in North Carolina. Coventry Healthcare (now Aetna) was the only other participating carrier in 2014, but only in a select number of counties, leaving BCBS as the lone insurer for many rural counties.

It remains to be seen what impact the entrance of a third competitor, United Healthcare, will have upon Marketplace premiums in 2015. Alaska and Louisiana are the only other two Marketplaces predicting double-digit rate hikes due to a similar combination of limited competition and skewed risk pools (see Update for Weeks of October 6th and 13th).

Tennessee



Plaintiffs insist that TennCare has yet to provide court-ordered hearings on delayed applications

The Tennessee Justice Center (TJC) is disputing claims this week by TennCare officials that the state is ahead of a court-ordered schedule to reduce nation's leading backlog of Medicaid applications.

TJC was one of the plaintiffs that successfully sought a federal injunction ordering TennCare to comply with federal Medicaid law and promptly hold hearings for any applicant delayed for more than 45 days (see Update for Weeks of August 25th and September 1st). However, TJC insists that TennCare has yet to schedule a single hearing.

TennCare officials maintain that the hearings have not been needed because they have resolved the technical issues delaying applications and resolved their eligibility status within the required 45 days. TJC claims that complaints received by their call center show that applicants are continuing to be denied medically necessary care while being "given the runaround" by state officials who claim the enrollee has missed a deadline or lacks the necessary evidence to file an appeal of a denied application..

The plaintiffs in the lawsuit had claimed that TennCare was deliberately "sabotaging" the process in order to "demonize the federal government" and create a justification not to expand Medicaid under the Affordable Care Act (see Update for Week of July 21st). TennCare has attributed the delays to an inability to validate applicant's reported income and citizenship status with the federal data hub. However, the Obama Administration has blamed Tennessee for relying on the federally-facilitated Marketplace to replace the state's Medicaid application process, after the state's \$35 million computerized eligibility system was not finished on time for 2014 open enrollment. It cited Tennessee as the worst state in the nation for meeting federal enrollment guidelines (see Update for Week of July 14th).

The federal court sided with the Obama Administration and granted the plaintiff's class-action status that will allow all unduly delayed applicants to be part of the lawsuit.

Utah

Legislature will wait to consider federally-approved Medicaid expansion alternative

Governor Gary Herbert (R) announced last week that he has reached a final agreement with the Obama Administration on a "private sector" alternative to the Medicaid expansion under the Affordable Care Act (ACA). However, he no longer intends to call the legislature into special session to consider his Healthy Utah plan (see Update for Week of March 3rd).

The Governor agreed with lawmakers that they need additional time to hear from constituents about the proposal to use \$258 million in ACA matching funds to purchase private Marketplace coverage for the newly-eligible population. He will sit down with newly-appointed House and Senate leaders after the midterm election in hopes of securing approval when the legislature convenes next January.

The Governor's plan is only a three-year pilot project that would require legislative approval at the initial and renewal stage. Passage is far from certain as it ran into a roadblock last session in the House where his likely challenger for re-election in 2016, House Speaker Becky Lockhart (R), opposed accepting any federal funds to expand Medicaid (see Update for Week of February 24th). However, the Governor said he remains confident the House will approve his plan next session, citing polls from consumer advocates like the Utah Health Policy Project showing that up to 88 percent of Utahns prefer it to doing nothing.

Healthy Utah largely follows similar "private sector" alternatives that the Obama Administration already approved for five states, where states can use the ACA matching funds to instead cover newly-eligible Medicaid enrollees in private plans. Governor Herbert insisted that the Administration has given Utah "more flexibility" than any other state, though he has yet to publicly release all of the final details.



The most contentious provision had been a requirement that “able-bodied” adults could only receive ACA subsidies if they were employed full-time or actively seeking such work. The Governor already backed-off that provision after the Obama Administration rejected a similar requirement advanced by Pennsylvania. Instead, Utah sought only to mandate that enrollees accept job training and work search assistance from the Department of Workforce Services (see Update for Week of September 8th). However, the Governor did state last week that the Administration will allow Utah to impose up to a \$50 copayment on emergency room services on certain higher-income Medicaid enrollees.

The Governor’s plan would extend Medicaid coverage to all 111,000 Utahns earning up to 138 percent of the federal poverty level (FPL) who are currently ineligible for Medicaid. Nearly 60,000 of this amount fall into the coverage gap and do not qualify for ACA subsidies.

Supporters of a traditional Medicaid expansion pointed to a recent Government Accountability Office audit warning that Arkansas’ “private sector” alternative is already expected to cost \$778 million more than a traditional expansion over the next three years (see Update for Week of September 8th).