Health Reform Update – Week of September 23rd, 2013

CONGRESS

House Republicans prepare new spending bill with fewer ACA defunding demands

As expected, the Senate voted this week to return a clean temporary spending bill (H.J.Res 59) to the House that would continue funding the government until November 15th without defunding the entire Affordable Care Act (ACA).

The government will shut down if the House and Senate cannot agree on some type of continuing resolution (CR) by September 30th end of the federal fiscal year, a move that will have little immediate impact on ACA implementation since most of its funding has already been obligated (see Update for Week of September 16th). The roughly 40 tea-party backed conservatives that forced the defunding provision to be attached to the initial CR continued this week to buck alternative riders by House leaders that sought more incremental ACA changes that have some Democratic support, such as repealing the medical device tax and Medicare cost-cutting board, or delaying the controversial individual mandate by one year consistent with the delay in the employer mandate (see Update for Weeks of July 1st and 8th).

However, by week's end, conservatives remained intent on demanding at least a one-year delay in the entire ACA, a position that is sure to be rejected by Democrats that control the Senate and heighten tensions with Republican leaders.

At least one Senate Democrat, Joe Manchin of West Virginia, did come out this week in support of delaying the individual mandate. However, he did not support the Republican plan to force a government shutdown if such a delay were not part of the CR.

Both the Congressional Budget Office and Urban Institute have found that such a delay in the individual mandate would actually increase the amount spent on ACA subsidies from an average of $700 to $1,100 and cause up to a 24 percent increase in premiums as fewer younger and healthier Americans enroll in the marketplaces. It would also increase uncompensated care costs for safety net providers.

House Speaker John Boehner (R-OH) has not ruled out attaching such riders to upcoming votes on a measure to raise the nation's debt ceiling before an October 17th default. However, several key Senate Republicans have warned against such a maneuver as causing another downgrade in the nation's credit rating (as occurred after the last debt ceiling fight in 2011) could destabilize the economy and result in an electoral backlash.

It is unclear at this point if Republicans even have enough votes in the House to make the debt ceiling increase contingent on "Obamacare" defunding riders, as they can afford only 16 defections if all House Democrats vote against the measure.

FEDERAL AGENCIES

Federal marketplaces will provide more competition and lower premiums than projected

The Department of Health and Human Services (HHS) released long-awaited individual plan premium data this week for the 36 states in which it will fully or partially-operate the new health insurance marketplaces created by the Affordable Care Act (ACA).

With open enrollment set to begin for all marketplaces on October 1st, average bronze and silver level premiums are now available for all marketplaces except those that are state-operated in Hawaii, Kentucky, and Massachusetts. For the 47 other states and the District of Columbia, the average individual premium for the second-lowest cost mid-level silver plan will be only $328 or 16 percent less than the Congressional Budget Office initially projected. In 15 states, this average will be less than $300 per month, or $1,100 per year below projections.

For all states, the average individual premium for the basic lowest-cost bronze plan is $249. For a 27-year old, the rate falls to just $163 per month, or $93 after accounting for premium tax credits.

According to the HHS report, the lower premiums are due to a healthy level of competition that was fostered in most federal, state, and partnership marketplaces. At least 95 percent of individual marketplace consumers will have a choice of two or more health insurers, and as a result they live in states where premiums are lower than expected. Roughly one in four participating insurers will be new entrants to the individual market.

The level of competition in the ACA marketplace has largely mirrored the non-ACA market. States that have individual markets dominated by only 1-2 insurers will also have ACA marketplaces with only 1-2 insurers. However, states like California, Florida and Texas with healthy market competition will see broad participation in their ACA marketplace, despite their huge uninsured populations.

Overall, consumers in the 36 marketplaces under some federal control will be able to choose from an average of 53 qualified health plans (QHPs). However, there is a huge disparity among these marketplaces, ranging from a low of seven QHPs in Alabama to a high of 106 in Arizona and 102 in Florida. The 36 marketplaces average eight participating insurers, ranging from only one in New Hampshire and West Virginia to 13 in Wisconsin.

Among all 47 states and DC, average monthly premiums for individuals also vary widely, with the most rural states of Wyoming and Alaska leading the way ($516 and $474 for the second-lowest cost silver plan). Minnesota's state-based marketplace (SBM) was far and away the most affordable, with a $192 average for the second-lowest cost silver plan (falling to $144 for the lowest-cost bronze plan). Tennessee's federally-facilitated marketplace (FFM) was the next closest at $245 and $181 respectively, followed by Oregon's SBM ($250 and $205) and Arizona's FFM ($252 and $214). However, the FFM in Kansas was surprisingly close behind at $260 and $197, despite having only two participating insurers.

For a family of four, the average monthly premium for the second lowest-cost silver coverage ranges from $584 in Tennessee and $600 in Arizona up to $1,131 in Alaska and $1,237 in Wyoming.

HHS reiterated that six in ten individual marketplace consumers will be able to purchase coverage for less than $100 per month after accounting for tax credits offered to those earning 100-400 percent of the federal poverty level (see Update for Week of September 16th), with options in some states like Mississippi costing as little as $8 per month for a 27-year old earning $25,000 per year (see below). The same 27-year old living in Dallas, TX could purchase a bronze plan for only $83 per month after tax credits, while a family of four earning $50,000 per year could purchase a bronze plan for only $24 in Fort Lauderdale, FL, $32 in St. Louis, MO, $36 in Charlotte, NC, and no payment in Anchorage, AK.

HHS emphasized that it is impossible to compare marketplace premiums with the current individual market, since the ACA marketplace will require a far broader benefit package, remove lifetime and annual caps, prohibit higher premiums based on gender or health status, and limit out-of-pocket costs. The agency will not provide details until October 1st for premiums offered by specific insurers in the 36 marketplaces under federal control, as well as for the more costly gold and platinum options.

Online enrollment in federal SHOP marketplace delayed until November

The Department of Health and Human Services (HHS) announced this week that online enrollment in the Affordable Care Act (ACA) marketplace for small businesses will not be available until

November 1st, although open enrollment will start as planned on October 1st. Instead of the online version of the application, HHS will post a PDF version. Applications will still be taken by phone, mail and fax.

HHS emphasized online applications for the individual marketplace will still be available on October 1st with full accessibility for consumers to compare plan options.

The HHS notice emphasizes that state-based Small Business Health Options Program (SHOP) marketplaces remain free to decide whether to delay online enrollment. Maryland has already delayed open enrollment until January 1st with coverage taking effect in March (see Update for Weeks of July 1st and 8th). The executive director for the DC Health Link marketplace insisted that despite the District of Columbia's delay in online subsidy determinations for the individual marketplace, the SHOP marketplace is ready to begin all online enrollment functions next week (see below).

The delay is likely to have more of a political than practical impact, as open enrollment in SHOP exchanges is not time limited, so that small employers can enroll on a monthly basis throughout the year. However, ACA opponents were quick to use the delay as evidence of an overall lack of readiness, as it is the latest in a series of postponements related to employers.

HHS has previously delayed enforcement of the requirement that small business marketplaces allow workers to choose from more than one plan (see Update for Week of March 11th). That provision has been delayed until 2015, although most state-based marketplaces will provide a choice of small business plans in 2014 (see Update for Week of May 27th). The Department of Treasury has also delayed enforcement until 2015 of the ACA mandate that large employers provide minimum coverage and value or pay a per employee assessment (see Update for Weeks of July 1st and 8th).

Medicaid applications, Spanish website will be delayed in federal marketplace

The Centers for Medicare and Medicaid Services (CMS) acknowledged this week that the Affordable Care Act (ACA) marketplaces it will operate will not be able to electronically transfer Medicaid applications to state-based marketplaces when open enrollment starts on October 1st. As a result, marketplace applicants that qualify for Medicaid will have to enroll directly through their respective state Medicaid office until at least November 1st.

In addition, CMS announced that the Spanish language version of the www.healthcare.gov website through which applicants must enroll will not be available until at least October 21st, potentially complicating enrollment of a key demographic that the agency has identified as critical to the success of the marketplaces. However, the agency emphasized the Spanish speakers will be available to start processing applications next week by telephone.

CMS proposes regulations for delayed Basic Health Plan option under ACA

The Centers for Medicare and Medicaid Services (CMS) issued proposed rules late last week that would implement the Basic Health Plan (BHP) option authorized by the Affordable Care Act (ACA).

The ACA provides states with additional federal funding should they choose to exercise the BHP option for those earning 133-200 percent of the federal poverty level (FPL) that do not qualify for Medicaid but would still have trouble affording any an ACA marketplace plan even with premium and cost-sharing subsidies. The program would save money for CMS as it would pay only 95 percent of what an individual would receive from subsidies, while consumers would benefit from coverage that has less cost-sharing and does not require them to pay back all or part of the subsidies should their income increase during the year.

The agency was heavily criticized by Democratic lawmakers earlier this year for delaying the provision until 2015 in order to focus on other marketplace regulations (see Update for Weeks of January 28th and February 4th). Some state-based marketplaces also sought a delay fearing the BHP option could threaten the financial viability of their marketplace by siphoning away enrollment during the critical early

stage of development (see Update for Week of July 25, 2011). Senator Maria Cantwell (D-WA), who included the BHP as part of the ACA based on a similar program in her home state, demanded that CMS finalize BHP regulations in early 2014 as a condition of her support for the nomination of CMS Administrator Marilyn Tavenner (see Update for Week of March 25th).

The proposed rule lays out the procedures for certifying a state's BHP, including eligibility, enrollment and benefit requirements. It also explains how states can use ACA funds for BHPs and what the guidelines should be in place for consumer payments.

Federal workers will not see additional premium increases from ACA

Premiums in the Federal Employees Health Benefits Program (FEHBP) will rise an average of four percent for 2014 with no significant increase in cost-sharing, according to the Office of Personnel Management (OPM).

Even though premiums for the popular program have increased by the same amount for the third consecutive year, OMB emphasized that the four percent increase is below industry estimates for other large employer plans in 2014, as well as the seven percent annual increases that FEHBP experienced in the prior three-year stretch. The agency also insisted that it was not attributable to the new consumer protections under the Affordable Care Act (ACA) that go into effect next year.

OMB pointed out that competition in FEHBP will increase by ten additional plans for 2014 (to 256 plans) and that premiums for the largest plan, the Blue Cross-Blue Shield standard option, will increase by only 2.2-2.4 percent.

The federal government pays an average of 70 percent of the total premium cost for FEHBP enrollees, which it will continue to do for members of Congress and their staff even though the ACA requires that they move to the new ACA marketplaces (see Update for Week of August 5th).

More Medicare Advantage enrollees will be in higher-rated plans in 2014

Enrollment in high-rated Medicare Advantage (MA) plans will increase substantially in 2014 despite a $1.64 increase in premiums.

According to the acting principal deputy administrator for the Centers for Medicare and Medicaid Services (CMS), 43 percent of MA enrollees will be enrolled in four-star plans next year compared to only 28 percent in 2013. Those enrolled in the highest-rated five-star plans will remain at nine percent, meaning that more than half of MA enrollees will be in four or five-star plan.

The star rating system was created as part of the quality bonus system for MA plans authorized by the ACA. It was intended to encourage enrollees to enroll in higher quality plans and appears to have that effect, according to the acting director. More than one-third of MA plans are now rated at least four stars, a 28 percent jump from 2013. However, he acknowledged that CMS internal audits did not show that the higher-rated plans always scored the best for quality measures.

Despite the slight increase in MA premiums next year to roughly $32.60, the acting director stressed that MA premiums are down by 9.8 percent since the implementation of the ACA.

HEALTH CARE COSTS

Private plan enrollees faced five percent jump in out-of-pocket costs last year

The Health Care Cost Institute reported this week that the 4.8 percent increase in out-of-pocket health spending for private plan enrollees in 2012 outpaced the overall growth rate of health care spending among private plan enrollees under age 65.

The study analyzed data from 156 million working age adults that had employer-sponsored health coverage through Aetna, Humana and UnitedHealthcare from 2009-2012 It found that while health spending for this group went up four percent to $4,701 from 2011-2012, out-of-pocket costs increased nearly a full percent more to $768 per person.

Out-of-pocket spending was greatest for those aged 55-64 at $1,265 per person, but increased over twice as much (5.4 percent to 2.5 percent) among those under age 18. Out-of-pocket costs for women were also more than $200 greater than for men.

STATES

DC and Colorado join list of state-based marketplaces facing early technology glitches

Officials with the state-based Affordable Care Act (ACA) marketplaces in the District of Columbia and Colorado acknowledged this week that individual plan applicants will not be able to determine online if they qualify for premium tax credits for the first month after open enrollment begins on October 1st.

The delay resulted after extensive systems testing produced a "high error rate". Officials for both marketplaces emphasized that consumers can still receive these determinations over the phone.

Although Congressional Republicans pounced on the delays as evidence that implementation of the entire law should be delayed (see above), officials with the marketplaces and the Centers for Medicare and Medicaid Services (CMS) emphasized that the glitches should not delay coverage, which does not begin until January 1st for those whose applications are processed before December 15th.

California and Oregon are among the state-based marketplaces that have already delayed online enrollment and will require applicants to initially go through brokers or agents.

Medicaid programs struggle to meet October 1st deadline for open enrollment

The National Association of Medicaid Directors (NAMD) acknowledged this week that as of September 15th at least 20 state Medicaid programs were only halfway done in completing the testing and upgrades needed to connect with the new federal data hub.

Federal officials certified the data hub earlier this month (see Update for Week of September 9th), insisting that it would be ready on October 1st to provide states with access to the federal databases needed to verify income, citizenship, and other eligibility criteria for health insurance marketplaces, Medicaid, SCHIP, and other state and federal health programs.

However, NAMD found that many states may still be in the testing phase when open enrollment begins October 1st and unable to connect to the data hub to verify income and eligibility for Medicaid. At least four states have already delayed certain online enrollment functions as a result of errors that surfaced during their testing (see above).

NAMD did not reveal which states lagged behind, but found that none had completed all nine of tasks identified in the NAMD survey.

The states that reported information were about three-fourths of the way done on such ACA requirements issues as changing their income verification systems to the Modified Adjusted Gross Income and developing streamlined applications. They also were far behind on securing federal approval for their benefit designs.

<u>Alabama</u>

Three insurers await approval to participate in ACA marketplace

With only one week to go until open enrollment, neither the state nor federal government has approved plans from three insurers to participate in the federally-facilitated marketplace (FFM) to be operated in Alabama pursuant to the Affordable Care Act (ACA).

The Department of Insurance is reviewing plans from Blue Cross and Blue Shield of Alabama, UnitedHealthcare and Humana to participate in the FFM for individual plans, although the Obama Administration will have the final say since Alabama has defaulted to full federal control.

The participation from all three insurers is critical to the success of the marketplace, as Alabama has one of the least competitive health insurance markets in the nation. According to a 2012 report from the American Medical Association, 88 percent of the state's market is controlled by Blue Cross while UnitedHealthcare is a distant second at only five percent.

According to a report released this week by the U.S. Department of Health and Human Services, states with eight or more participating insurers will have the most affordable marketplace premiums, while premiums are typically much higher for marketplaces with only a handful of participants (see above). However, monthly premiums for Alabama's FFM are expected to be just under the national average of $328 for the second-lowest cost silver plan and $249 for the lowest cost bronze plan, or almost 30 percent less than neighboring Mississippi, where marketplace competition is far more limited (see below).

Roughly 642,738 Alabamians are uninsured and eligible to shop on the FFM. However, a whopping 95 percent of that group is expected to qualify for tax credits under the ACA to offset the cost of the premiums.

Arkansas

Obama Administration approves "private sector" alternative to Medicaid expansion

The Center for Medicare and Medicaid Services (CMS) formally approved Arkansas' request for a federal waiver this week that it will allow it to use Affordable Care Act (ACA) funds for expanding Medicaid to instead cover newly-eligible populations in the state partnership marketplace (SPM).

The so-called "private option" alternative sought by Governor Mike Beebe (D) quickly became a model for several conservative-leaning states since it was conditionally approved by CMS earlier this year (see Update for Week of March 25th). Republican governors in Indiana, Iowa, Michigan, Pennsylvania (see below), and Tennessee have proposed similar alternatives as a means to circumvent opposition from Republican-controlled legislatures, though with other conditions such a sliding-scale premiums.

Under the terms of the waiver, Arkansas must re-secure federal approval in 2017 to continue the waiver, which will extend to all adult populations under Medicaid. Those moved from Medicaid to the SPM will be limited to the "silver" plan, the second cheapest category covering roughly 70 percent of costs, although CMS cost-sharing limits for traditional Medicaid enrollees still apply. The state will also provide wrap-around benefits to ensure the waiver population meets Medicaid coverage requirements.

Most Republican lawmakers supported the waiver, although staunchly conservative groups Conservative groups like Arkansans against Big Government are attempting to place a referendum on the November 2014 ballot that would allow voters to void the enabling legislation for the "private option" (see Update for Week of June 24th).

State officials have disputed Congressional Budget Office (CBO) estimates that covering expansion populations through marketplace plans would cost $3,000 more per enrollee (see Update for Week of March 18th).

Final premiums for partnership marketplace reduced by up to 25 percent

The Insurance Department released final individual premiums this week for the state partnership marketplace (SPM) that will be operated in Arkansas pursuant to the Affordable Care Act (ACA).

Under the terms of the federal-state partnership approved by the Obama Administration, the Insurance Department will retain control over rate review and plan certification. According to state officials, the final rates are up to 25 percent below what participating insurers sought for the 71 qualified health plans (QHPs). However, an Obama Administration report (see above) found that monthly premiums for the second-lowest cost silver plan will average $366 and $275 for the lowest-cost bronze plan, well above the respective national average of $328 and $249. However, the Insurance Commissioner emphasized that approved SPM rates were still ten percent below what the Society of Actuaries predicted for the individual market.

As with most state-based marketplaces (SBMs), the most costly but generous platinum level plans will not be available in the SPM. Consumers will have a choice of bronze, silver, or gold plans (as well as more limited catastrophic coverage for young adults). Premiums will vary only by age, geography, family size and tobacco use.

Per the Department, the average base premiums for 30-year olds will be $285 per month. A family of four earning $35,000 could pay only $118 per month after their $831 premium is reduced by the ACA tax credits.

The Legislative Council agreed to postpone its review of the $5.1 million marketing and outreach contract for the SPM, pending its review of the final premiums. However, several Republican lawmakers including Rep. Douglas House stated this week that they appear to be "reasonable".

California

Governor signs consumer protection bill with somewhat greater out-of-pocket limits than ACA

Governor Jerry Brown (D) signed another remaining element of the legislative implementation of the Affordable Care Act (ACA) this week. S.B. 639 proposed by the consumer group Health Access will limit out-of-pocket costs to the same federal health savings account limits imposed by the ACA (see Update for Week of August 12th). However, it goes beyond the ACA but setting the limits for all essential health benefits in 2015 at $6,350 for an individual or $12,700 for a family and not allowing a separate limit of $1,000 for other categories like out-of-network emergency room use.

S.B. 639 also protects small business workers by applying the ACA limits in 2014, even though federal regulations allowed small group plans to go above their $2,000 deductible limit if they can show that they cannot "reasonably" build a benefit package for the bronze level (the lowest actuarial value plan) without doing so (see Update for Week of February 18th).

Physician group seeks U.S. Supreme Court review of ten percent Medi-Cal cut

The California Medical Association (CMA) petitioned the U.S. Supreme Court last week to review an appeals court ruling that upheld a ten percent cut to Medi-Cal reimbursement rates for 2011.

The federal Centers for Medicare and Medicaid Services had approved the reduction retroactive to June 2011, however a three-judge panel of the Ninth U.S Circuit Court of Appeals blocked the cut the following year. The full Ninth Circuit Court upheld the cut last spring (see Update for Week of May 27th).

If implemented, the cut will start at $917 million for fiscal year 2013-2014 and one year later will increase to $1.4 billion. However, the Department of Finance has determined that the Department of Health Services has the authority to reduce the cut on their own if they believe it will restrict access to care and thus violate federal Medicaid law.

CMA argues that the ten percent cut, coming on top of similar reductions in prior years, will impede access, especially as the state expands Medi-Cal on January 1st pursuant to the Affordable Care

Act (ACA). However, it is not clear that the U.S. Supreme Court will even hear the case, since it previously declined to intervene (see Update for Week of February 20, 2012).

Delaware

Individual marketplace to offer affordable platinum coverage, despite little competition

The Insurance Commissioner announced this week that Delaware will be one of the few Affordable Care Act (ACA) marketplaces that offer the most costly but generous platinum-level coverage.

Highmark Blue Cross and Blue Shield, the state's dominant insurer, will offer one platinum plan with a base monthly premium of $330 with a deductible of only $300 for individuals and $600 for families and a ten percent coinsurance.

Highmark's decision to offer platinum coverage in Delaware contrasts with its refusal to do so in another partnership marketplace in West Virginia (see Update for Week of September 9th). According to the Georgetown University Health Policy Institute, only California, Massachusetts, New York, and Vermont are requiring plans to offer platinum coverage (see Update for Week of August 12th). The Obama Administration has yet to release any information for gold or platinum plans in federally-facilitated marketplaces (see above).

Coventry Health Care, an Aetna subsidiary, is the only other insurer participating in Delaware's state partnership marketplace (SPM). Highmark and Coventry will offer a total of 19 plan options. Coventry offers the lowest cost catastrophic and bronze plans (with base monthly premiums of $130 and $193 respectively), while Highmark has the lowest cost silver and gold plans ($224 and $269).

Coventry has the highest deductibles in bronze, silver, and gold plans, as well as the highest coinsurance (up to 30 percent in some bronze and silver plans).

An Obama Administration report found this week that average monthly premiums in Delaware would be slightly above the national average (see above). The second-lowest cost silver plan in Delaware will average $360 compared to $328 nationally while the lowest-cost bronze plan will average $308 compared to $249 nationwide. According to the report, this was consistent with the premiums in other states that were typically higher for marketplaces with less than three competing insurers.

Florida

Two largest counties to defy ban on marketplace navigators entering state property

Miami-Dade and Broward counties announced this week that they would defy the Department of Health (DOH) decree banning Affordable Care Act (ACA) enrollment assisters from operating in state or local health departments (see Update for Week of September 9th).

Florida was identified this week by Health Care America Now (HCAN) as one of 13 states trying to sabotage enrollment in the new ACA health insurance marketplaces by engaging in "navigator suppression". Florida is critical to the success of the marketplaces as have the nation's third largest uninsured population.

The Governor and Republican lawmakers already enacted legislation last session requiring licensure, as well as background and fingerprint checks. However, the tactic to affirmatively ban navigator and non-navigator personnel from helping to facilitate enrollment through health departments drew the ire of commissioners of the state's two largest counties. Despite a Republican majority, the Miami-Dade county commissioners followed Broward's lead and voted overwhelmingly to defy the ban. The Republican mayor of Miami-Dade and the commissioners also rejected the Governor's assertion that the assisters would obtain or comprise private medical information of consumers, noting that Medicare counselors have filled the same role in south Florida for years without such concerns.

Florida lags well behind in licensing navigators, having approved only 11 of 150 applications as of mid-week. However, the Department of Financial Services blamed technology glitches at the federal level from preventing applicants from completing the required training.

An Obama Administration report found this week that although monthly premiums for the federally-facilitated marketplace in Florida will be roughly the same as national averages ($328 for the second-lowest cost silver plan and $249 for the lowest-cost bronze plan), they will be well below those figures in south Florida counties due to the high number of competing insurers (see above). A family of four earning $50,000 per year in Fort Lauderdale (Broward county) could purchase a bronze plan for as little as $24 per month, after accounting for premium tax credits, and $18 per month in neighboring Palm Beach county. However, the same family in Orlando would pay $126 per month for the identical plan.

Idaho

ACA marketplace loses only for-profit insurer

The Affordable Care Act (ACA) marketplace that will initially be operated by the federal government in Idaho lost its only for-profit insurer this week that planned to serve the individual market.

The withdrawal by Altius Health Plans cut the number of plan options for individual consumers by nearly ten percent, leaving four non-profit companies to offer 146 plans in the marketplace. The move came after Altius was purchased by Aetna, which has already exited many ACA marketplaces nationwide including Connecticut, Georgia, Maryland, and New York (see Update for Week of August 26th).

Aetna indicated that it was open to returning in 2015, when Idaho plans to operate its own ACA marketplace (see Update for Week of August 12th).

Illinois

Partnership marketplace not yet fully operational, but premiums are well below national average

Governor Pat Quinn (D) acknowledged this week that the state partnership marketplace (SPM) operated in Illinois pursuant to the Affordable Care Act (ACA) may be just short of fully operational when open enrollment begins next week.

The call center for the Illinois Health Insurance Marketplace will not be ready on October 1st, nor has Illinois received the necessary federal approval yet for the eight insurers that intend to offer 165 plans to individual consumers.

Most residents will be able to choose from at least 34 plans no matter where they live, though in more urban areas like Chicago there will more plan options. Chicago will also have the most affordable premiums in the state thanks to the higher level of competition, with the lowest-cost plan for a 25-year-old nonsmoker costing only $120 before premium tax credits. For a 40-year-old nonsmoker, the lowest-cost plan would be $152, but rise to $266 for a 55-year-old nonsmoker.

The Society of Actuaries warned that as in other states, the affordable premiums come with a trade-off, as marketplace plans are offering a far more limited provider networks, often excluding very large and well-known hospital chains (see Update for Week of September 16th). The Department of Insurance acknowledged that provider networks are narrower in the marketplace, but echoed the findings of an Obama Administration report this week concluding that state insurance departments have plenty of existing mechanisms to ensure networks meet minimum state and federal adequacy standards.

The Governor's office refused to reveal which marketplace insurers are offering the lowest prices. The Obama Administration reported this week that monthly premiums in Illinois will actually be well below national average for the second-lowest cost silver plan ($286 compared to $328 nationally) and the lowest-cost bronze plan ($203 compared to $249). Only a handful of states led by Minnesota had lower premiums for these two plans (see above).

Mississippi

Lack of ACA marketplace competition results in premiums that are among the nation's highest

Insurance Commissioner Mike Chaney (R) blamed a lack of competition for federal marketplace premiums that will be among the highest in the nation.

According to premium data released by the Obama Administration this week, the average cost of a mid-range silver plan in the Affordable Care Act (ACA) marketplace that will be federally-operated for Mississippi will be $448 per month (before applying premium tax credits). This figure is 37 percent higher than the $328 average for 47 other states and the District of Columbia, and exceeded only by the average premiums for the nation's two most rural states ($474 for Alaska and $516 for Wyoming).

The Insurance Commissioner, who unsuccessfully fought for a state-based exchange (see Update for Week of February 11th), noted that only two insurers (Humana and Magnolia Health Plan) are participating in the federal marketplace. However, these two will compete in only four counties, leaving the 78 remaining counties in Mississippi with only one marketplace insurer.

The Commissioner won federal approval last month for his department to operate the small business marketplace under the ACA, despite federal control over the individual version (see Update for Week of September 2nd). He insists greater competition will allow for lower premiums in the small business marketplace, claiming that up to seven plans will participate.

The Obama Administration report documented that marketplace premiums were highest in states like Mississippi, Alaska, and Wyoming that are dominated by only 1-2 insurers

Despite the high premiums, the Mississippi Health Advocacy Program pointed out that rates will still be very affordable for some consumers. For example, a 27-year old earning $25,000 per year and living in the state capitol of Jackson could pay only $8 per month for the least expensive and least comprehensive plan, after accounting for tax credits.

Missouri

House committee to draft Medicaid expansion alternative

The House Interim Committee on Medicaid Transformation decided this week to draft legislation that would provide an alternative to the Medicaid expansion under the Affordable Care Act (ACA).

The Republican supermajority has thus far blocked any consideration of the plan by Governor Jay Nixon (D) to participate in the ACA expansion (see Update for Week of March 11th) and a voter-passed ballot referendum blocks any state officials from implementing such a plan (see Update for Week of November 5th).

However, Republican lawmakers have been under pressure from physician, provider, and consumer groups not to increased uncompensated care costs by simply opting-out of the expansion. As a result, they agreed to consider four "private sector" alternatives being advanced by Arkansas, Indiana, Iowa, and Congressman Paul Ryan (R-WI). Only the Arkansas plan, where ACA funds would pay for the newly-Medicaid eligible to purchase marketplace coverage, has federal approval (see above).

Committee chairman Rep. Jay Barnes (R) stated that the committee would hold several hearings in the coming weeks with the goal of pre-filing legislation by December for consideration in the 2014 session. He also insisted the committee was not averse to approving plans to go beyond the new eligibility threshold in the ACA (138 percent of the federal poverty level), so long as new Medicaid enrollees were covered under private plans instead of Medicaid.

Pennsylvania

Senate votes to lift six-month waiting period for SCHIP

The Senate voted this week to eliminate the six-month waiting period for the State Children's Health Insurance Program (SCHIP) and reauthorize the program that provides state-subsidized coverage to 187,000 children.

The waiting period was intended to discourage families from dropping private coverage in order to receive SCHIP. However, Governor Tom Corbett (R) proposed eliminating it after SCHIP enrollment shrunk by 65,000 since he took office.

The House previously approved the measure (H.B. 108) but must vote on it again due to Senate amendments. It is part of the Governor's belated proposal last week to use Affordable Care Act (ACA) funds to move those that the ACA makes eligible for Medicaid into the federal marketplace to be operated in Pennsylvania. Federal approval for his "private sector alternative" to expanding Medicaid under the ACA is very uncertain as it would also impose premiums on those earning less than 100 percent of the federal poverty level (see Update for Week of September 16th).