



Health Reform Update –Weeks of June 30 and July 7, 2014

CONGRESS

Supreme Court exempts for-profits with religious objections from preventive services mandate

In a narrow decision that may ultimately impact coverage for HIV/AIDs or other health services, the U.S. Supreme Court last week exempted closely-held for-profit companies from the Affordable Care Act (ACA) requirement that their health plans cover contraceptives.

Lower courts had split on whether the ACA provision that requires coverage of certain preventive services without cost-sharing could be applied to closely-held companies that object to certain contraceptives on religious grounds. The case was brought by two craft stores owned by religious families that refused to cover several of the 20 mandated forms of FDA-approved contraception, arguing that they were equivalent to abortion.

The Supreme Court ruling broke along familiar ideological lines, with the court's five conservatives concluding that the ACA requirement violates the Religious Freedom Restoration Act of 1993 as it relates solely to closely-held companies. However, the decision specifically left the contraceptive requirement intact for publicly-traded companies and suggested the federal government could fill the void by instead covering the costs of the contraceptives at issue.

The dissent by the court's four liberal justices warned that closely-held companies could expand the ruling to refuse coverage for a wide range of medical care to which they purport to object on religious grounds, including blood transfusions, vaccines, or HIV/AIDS treatments. The four justices also stressed that the decision failed to define "closely-held companies", which could constitute 52 percent of the American workforce according to certain studies. House Minority Leader Nancy Pelosi (D-CA) argued that based on the Internal Revenue Service's definition ("closely-held" means five or fewer people hold more than half of the value of the outstanding stock), the exemption created by the Supreme Court could theoretically apply to more than 90 percent of American companies.

In response, Senate and House Democrats promptly introduced legislation this week (S. 2578 and H.R. 5051) that would reverse the Supreme Court's decision by barring for-profits from seeking any exemptions to the ACA preventive services mandate (non-profit religious institutions could still opt-out). The Senate bill sponsored by Senator Patty Murray (D-WA) and Mark Begich (D-AK) already has 35 cosponsors but will likely be unable to clear the Republican-controlled House.

It remains unclear whether the Obama Administration could create an administrative fix to counter the Supreme Court's ruling. However, the issue will likely be featured in this fall's election campaigns.

Costly Hepatitis C drug garners bipartisan scrutiny

Senate Finance Committee chairman Ron Wyden (D-OR) and ranking member Chuck Grassley (R-IA) sent a letter this week to Gilead Sciences requesting pricing information for its recently-approved Hepatitis C (HCV) drug Sovaldi.

The drug has been hailed as breakthrough treatment for the 3.2 million Americans infected with HCV but been widely criticized for its \$1,000 per pill price tag. The Senators note that the \$84,000 cost for one course of treatment could actually double to \$168,000 for those requiring longer treatments and does not reflect the cost of drugs used in combination treatments.



Managed care plans contracted with Medicare Part D or Medicaid have expressed concerns in recent months that the cost of the drug could force them to incur unsustainable financial losses under the capitated rates negotiated prior to Sovaldi's approval in December. The Senators claim that the drug's cost "appears to be higher than expected given the costs of development and production and the steep discounts offered in other countries [such as \$900 in Egypt]." As a result, they are asking Gilead to provide them within 60 days with an accounting of how it arrived at the \$84,000 price, which it insists the original developer (Pharmasset, Inc.) expected to profitably sell at only \$36,000 for a course of treatment.

Among other details, the Senators requested information on (i) fairness opinion documents from Morgan Stanley analysts in conjunction with Gilead's offering price, (ii) communications between Gilead and Pharmasset regarding the price, and (iii) an itemized accounting of research and development costs.

The letter follows a similar request issued last month by House Democrats, citing studies showing that Part D coverage of Sovaldi will by itself increase Medicare drug spending by eight percent in 2015 (see Update for Week of June 16th).

Rep. Henry Waxman (D-CA) used the Sovaldi price as further evidence that Congress should give Medicare Part D authority to negotiate drug prices or require rebates from manufacturers, noting that a recent Government Accountability Office (GAO) report found that brand-name drug prices under Part D are 69 percent higher than Medicaid or Department of Defense programs that have such authority.

House leaders seek lawsuit against President for failing to fully enforce ACA

The House Rules Committee released a draft resolution this week that would authorize a lawsuit against President Obama for delaying the employer mandate under the Affordable Care Act (ACA).

Speaker John Boehner (R-OH) insisted that the delays first initiated in July 2013 went beyond the President's established executive authority to interpret and enforce laws of Congress. In waving and failing to enforce the employer mandate penalties set by the ACA statute without a vote of Congress, he claimed that the President violated the constitutional separation of powers by actually writing law.

Democrats and Republicans brought competing constitutional scholars to a committee hearing this week to debate the merits of such a lawsuit, which is largely viewed as not likely to succeed given the traditionally broad authority granted to the executive branch to interpret and enforce laws.

The employer mandate has been delayed until 2016 for those with 51-100 employees, but only until 2015 for those with more than 100 employees (see Update for Week of February 10th).

FEDERAL AGENCIES

OIG confirms that CMS is unable to verify income and citizenship for Marketplace applicants

The Centers for Medicare and Medicaid Services (CMS) promptly agreed this week to develop and publicly disclose an action plan for fixing up to 2.9 million inconsistencies that the Health and Human Services (HHS) Office of Inspector General (OIG) identified in applications filed through federally-facilitated Marketplaces (FFM) created by the Affordable Care Act (ACA).

CMS fully or partially operates the FFMs in 36 states. However, the OIG concluded that CMS is unable to resolve applications errors manually and lacked the basic capabilities needed to address discrepancies in data reported by applicants and those on file in federal databases (such as income and citizenship). The report also noted that less than one percent of the 330,000 inconsistencies that CMS could address have been actually resolved.



The report adds fuel to concerns by Republican lawmakers that applicants are receiving premium or cost-sharing subsidies to which they are not legally entitled. However, Republican Senators this week did not go as far as their House Republican colleagues in demanding the Department of Treasury stop making subsidy payments until all application data can be verified (see Update for Week of June 2nd).

CMS previously acknowledged roughly two million such inconsistencies and emphasized that a mere inconsistency in certain data does not automatically indicate that it is erroneous (see Update for Week of June 2nd). However, CMS did agree to identify steps it can take to manually clear the current backlog create an automated system later this summer so that inconsistencies can promptly be resolved.

The OIG is also urging CMS to heighten its oversight of state-based Marketplaces after the OIG found that at least four (California, Massachusetts, Oregon, and Vermont) are experiencing similar verification struggles.

GAO finds that most insurers met ACA limits on profit and overhead

A new report this week from the Government Accountability Office (GAO) determined that about 75 percent of health plans met the new medical-loss ratios (MLRs) required by the Affordable Care Act (ACA) in 2011 and 2012.

The MLRs required individual and small group plans to spend at least 80 percent of premium revenue on direct medical care instead of profit and overhead (or 85 percent for large group plans). Those that failed to comply had to refund the difference to consumers.

According to GAO, insurers in all markets spent a median of 88 percent on medical care in both years, with the amount of refunds cut in half from 2011 to 2012 (\$1.1 billion to \$520 million). Nearly one-third of all individual market insurers had to issue refunds in 2012, compared to only 18.6 percent of small group insurers and 13.7 percent in the large group market.

GAO estimated that insurers would have saved about 75 percent on those refunds if plans were permitted to include agent and broker fees in their MLR calculations.

New studies shows consumer satisfaction with Marketplace plans, drop in uninsured

The Commonwealth Fund released its survey this week of more than 4,400 working adults showing that the vast majority are satisfied with coverage obtained from the Affordable Care Act (ACA).

The survey showed that 73 percent were satisfied with the private plan coverage they purchased from the new health insurance Marketplaces (including 74 percent of those that identified as Republican), a figure that rose to 87 percent for those that enrolled in Medicaid. The survey from April-June, which was compared to previous results obtained before the Marketplaces opened last October, found that 62 percent reported that they could not afford or access the treatment they needed without the new coverage, with 81 percent stating that they “were better off now than before they had their coverage.”

Researchers also used the survey results to estimate that the overall percentage of uninsured adults dropped from 20 to 15 percent during the same time period, with 9.5 million gaining coverage. The uninsured rate for young adults age 19-34 dropped even more precipitously (28 to 18 percent), while the rate for Latinos (who traditionally have the highest percentage of uninsured) fell from 36 to 23 percent.

Regionally, the largest decrease was among the western states, where the uninsured rate fell from 21 to 12 percent (including a drop of 22 to 11 percent in California). Southern states (most of whom did not participate in the ACA's Medicaid expansion) saw only a five percent decline (24 to 19 percent).



The average uninsured rate among all Medicaid expansion states dropped from 28 to 17 percent, but remained around 36 percent for the 24 states that had yet to expand by June.

Two other studies released this week confirmed a similar drop in the uninsured rate after the October 1st opening of the Marketplaces. The Urban Institute determined that eight million Americans have subsequently gained health coverage while the latest Gallup-Healthways survey pegged the uninsured rate at 13.4 percent, the lowest since 2008. The findings are consistent with earlier surveys by Gallup (see Update for Week of April 14th) and RAND (see Update for Week of April 7th), with the latter concluding that the ACA extended coverage to 9.3 million Americans.

STATES

CMS gives six states a deadline to address backlogs of Medicaid applications

The Centers for Medicare and Medicaid Services (CMS) issued a June 27th directive giving six states ten business days to develop a plan to correct persistent backlogs in Medicaid applications.

Alaska, California, Kansas, Michigan, Missouri and Tennessee have had ongoing problems with Medicaid eligibility and enrollment systems since the new Affordable Care Act (ACA) health insurance Marketplaces opened on October 1st.

The problems are limited to “account transfer” issues in four of the states, frequently preventing them from communicating with the federally-facilitated Marketplace (FFM) in order to verify applicants are eligible for Medicaid and not Marketplace coverage. Missouri is unable to send Medicaid application files to the FFM, while Alaska cannot receive and process accounts from the FFM. Kansas and Michigan (which has more than 85,000 Medicaid applications pending) cannot send, receive and process accounts in either direction, according to CMS.

The states have largely blamed CMS for the account transfer problems, noting that functionality was limited after the flawed rollout of the web portal on October 1st (see Update for Week of November 11th) and functionality has never been fully restored. CMS acknowledges the system is not working as it should nationwide, but singled out those that have failed to update mitigation plans for resultant backlogs.

CMS specifically targeted Tennessee for failing to meet almost all of the seven “critical success factors” that the agency outlined in Medicaid eligibility and enrollment rules. The state’s \$35 million computer system to determine Medicaid eligibility has been delayed until September or nearly a year after CMS’ deadline. As a result, CMS noted that Tennessee is unable to accept a single, streamlined application, convert existing state income standards to the ACA’s Modified Adjusted Gross Income, respond to FFM inquiries, or verify eligibility from the federal data hub or other electronic sources.

The CMS letter does not explicitly threaten to withhold federal matching funds if states failed to adequately respond, as former Health and Human Services (HHS) Secretary Kathleen Sebelius initially proposed last spring in testimony before Congress. Republican lawmakers have pushed CMS not to take such punitive action.

The largest backlog remains in California, where more than 600,000 applicants are awaiting enrollment in Med-Cal. However, state officials stress that their backlog has been reduced by 33 percent since May (see Update for Week of June 2nd) and more than half of the remaining 600,000 are within the 45-day window that the counties are allowed to enroll people into Medi-Cal. They also point out that more than two million Californians have been successfully enrolled in Medi-Cal since October 1st.

Despite the backlogs, the Urban Institute determined that all states have already reached 47 percent of their projected increase in Medicaid enrollment by 2016.



California

Anthem sued for erroneous provider directories

The advocacy group Consumer Watchdog filed suit this week against Anthem Blue Cross alleging that the insurance giant misled “millions of enrollees” about whether their doctors and hospitals were included in provider networks for their new Covered California plans.

Erroneous provider directories initially plagued all insurers in the state-based health insurance Marketplace (see Update for Week of October 21st). However, Consumer Watchdog insists that Anthem failed to disclose the errors and omissions to consumers, often leaving them responsible for thousands of dollars in unnecessary out-of-pocket costs.

The class action lawsuit also claims that Anthem willfully delayed providing full information to consumers until it was too late for them to change coverage. The insurer is also accused of failing to disclose that it had stopped offering any plans with out-of-network coverage in four of the state's biggest counties (Los Angeles, Orange, San Francisco and San Diego).

Two similar lawsuits were filed in May and June by consumers that claim they were misled into enrolling in exclusive provider organization (EPO) plans, which typically offer little to no coverage for out-of-network doctors, instead of more generous preferred provider organization (PPO) plans.

Anthem, the state's largest insurer for individual health plans, acknowledged errors in the provider directories listed on the Covered California website and has agreed to pay the claims of those who received treatment from inaccurately listed doctors during the first three months of the year. However, Anthem is refusing to extend that policy for consumers that did not discover the errors prior to March 31st.

Consumer Watchdog notes that "misconduct or misinformation" that may have occurred during the enrollment period as well as "incorrect plan data" that may have been presented when selecting a plan are designated as “qualifying life events” that should allow applicants to enroll in a health plan outside of the designated open enrollment periods.

Anthem controlled the largest share (30 percent) of the Covered California Marketplace during the inaugural open enrollment period (see Update for Week of April 14th). However, the Department of Managed Health Care is already investigating whether Anthem and Blue Shield of California intentionally sought to mislead consumers about whether their doctors and hospitals were in the narrower networks created for their Marketplace plans after their "preliminary investigation gave us good cause to believe there are violations of the law."

State insurance regulators acknowledge that the majority of more than 1,800 consumer complaints launched against Marketplace plans related to narrow provider networks that were prevalent in Marketplaces nationwide during the inaugural open enrollment period (see Update for Weeks of March 17th and 24th). They have verified that in some cases only 33 percent of area physicians were accurately listed within these provider networks.

Governor signs bill delaying ACA coverage mandate for small businesses

Governor Jerry Brown (D) signed a bill into law this week that gives companies with fewer than 50 employees an extra year to obtain health coverage that complies with the Affordable Care Act (ACA).

Under the ACA, all health plans must include the ten essential health benefit categories set forth in the statute or be canceled by the end of 2014. S.B. 1446 extends that deadline to the end of 2015.



The law takes effect immediately and allows small businesses to renew coverage at any point in the year. It was backed by Insurance Commissioner David Jones (D) and the National Federation of Independent Business (NFIB), although NFIB had initially sought a three-year reprieve.

Insurance regulators deem \$250 million in premium increases unreasonable

The advocacy group Consumer Watchdog released a study last week showing that roughly \$250 million in premium increases for individual health plans have been deemed “unreasonable” by state regulators over a 15-month period ending in November 2013.

The report was intended to bolster the group’s November ballot referendum that would give Insurance Commissioner David Jones (D) his long-sought authority to modify or reject excessive rate hikes. The Commissioner cited the report in his testimony before the legislature last week, noting that his office’s determination that rates are “unreasonable” and not support by actual medical costs is “not binding” upon health insurers in California.

As an Assemblyman, Jones unsuccessfully sponsored legislation that would give the commissioner greater authority over rate hikes (see Update for August 29, 2011). However, both the California Medical Association and the Covered California insurance Marketplace oppose the move, insisting that it might reduce physician reimbursement and cause insurers to leave the individual market.

Colorado

Marketplace to stay in black despite higher than anticipated forecast for dropped policies

Officials with the Connect for Health Colorado insurance Marketplace created by the Affordable Care Act (ACA) predicted this week that nearly twice as many subscribers may drop or decline to pay for Marketplace policies in fiscal year 2015, which could result in \$1 million less revenue than projected.

The Marketplace had estimated last spring that about 13 percent of people would drop or not pay for policies next year, but upgraded that figure to 24 percent and an additional 22 percent in fiscal 2016. The revisions are based on new figures nationwide and still leave the Marketplace with more revenue than expenses in fiscal 2015, though diminished reserves needed to ensure the Marketplace is financially sustainable if claims costs are higher than anticipated.

Connect for Health Colorado does impose a user fee on every Marketplace policy as well as a 1.25 percent assessment on every individual and small group plan in the state. These fees should still provide the Marketplace with nearly \$7 million in revenue for fiscal 2015, despite the \$1 million decline.

Connecticut

Anthem defends double-digit rate hike, blames pharmaceutical costs

Anthem Blue Cross and Blue Shield testified at a public hearing last week that its proposal to increase 2015 individual market premiums by an average of 12.5 percent is necessitated largely by the rising costs of prescription drugs, particularly the \$84,000 annual price tag for the latest Hepatitis C (HCV) treatment (see above), which cost Anthem \$430,000 in claims just during May. The insurer also blamed a new state law requiring that physicians offer HCV testing to patients born from 1945-1965.

The Insurance Department held the hearing to determine the reasonableness of Anthem’s rate hike, which could hike rates for individual health plans in and outside of the new AccessHealthCT Marketplace created pursuant to the Affordable Care Act (ACA). The Department has the authority to modify or reject any rate hikes that it finds to be not actuarially justified, excessive, or discriminatory.

In addition to prescription drug costs, Anthem also attributes smaller portions of the increase to fees imposed by the ACA, as well as a decline in utilization that occurred despite a gain in 5,000



individual plan consumers during 2014 (Anthem now offers individual plans to more than 66,000 consumers in Connecticut).

Two other participants in AccessHealthCT (ConnectiCare and the HealthyCT cooperative created with ACA loans) are proposing average premium hikes nearly 12 and nine percent respectively). However, the premiums may be voluntarily downgraded somewhat depending on the premiums proposed by insurance giant UnitedHealth Care, which plans to enter the AccessHealthCT Marketplace in 2015, as well as the Marketplaces for Georgia, Florida, New Jersey, and New York.

Delaware

Marketplace premiums suffering from lack of competition

The Department of Insurance (DOI) announced last week that more than 21,000 consumers have enrolled in health coverage through either Medicaid or the state partnership Marketplace (SPM) since October 1st. Roughly 12,000 of the private Marketplace plan enrollment came from the state's dominant insurance carrier Highmark Blue Cross Blue Shield, which directly enrolled another 4,500 in ACA plans.

As of June 30th, just over 6,600 of these 21,000 gained coverage through the state's Medicaid expansion, a 14 percent increase since May 30th.

Coventry Health was the only insurer competing with Highmark in ChooseHealth Delaware. The lack of competition led to 2014 monthly premiums that were higher than the national average (\$392 compared to \$346), even though average premiums were nearly identical when accounting for premium tax credits (\$263 to \$264).

District of Columbia

CareFirst BCBS downgrades proposed Marketplace premiums for 2015

The District's dominant health insurer CareFirst BlueCross BlueShield (BCBS) voluntarily agreed to downgrade proposed rate hikes for the next year after initial filings revealed that their increases were out-of-line with the three other insurers participating in the DC Health Link Marketplace created by the Affordable Care Act (ACA).

CareFirst BCBS was the only insurer in DC Health Link that did not voluntarily reduce proposed premiums in 2014 after comparing it to initial filings by competitors (see Update for July 15-August 2, 2013). However, their proposed rate for 2015 included double-digit rate hikes for most of its individual plans and all of its small group offerings, including 15-19 percent hikes for platinum coverage offered under their individual PPO and HMO plans (see Update for Week of June 23rd).

By contrast, UnitedHealthcare proposed eight percent rate cuts for all 2015 plans, while Aetna and Kaiser Permanente sought a mix of increases and decreases that would result in a slight net decrease for Aetna and slight net increase for Kaiser.

CareFirst BCBS did last year's proposed 25 percent average increase for the Marketplace in Maryland last year cut in half by state regulators (see Update for July 15-August 2, 2013). DC Health Link can likewise adjust premiums upwards or downwards before final rates are approved before the November start of 2015 open enrollment.

Florida

Marketplace insurers using trade secret law to conceal rate hikes

The Office of Regulation (OIR) warned 15 health plans seeking to participate in the Affordable Care Act (ACA) Marketplace this week that a state law protecting "trade secrets" does not allow them to conceal premium increases for 2015 from public disclosure.



Despite the opinion from OIR's general counsel, the agency is complying with the procedures under the law by not releasing proposed rates until the insurers are allowed 30 days to challenge the disclosure in court. Consumer groups including Florida CHAIN have objected to the move and are demanding their initial release after Marketplace plans simply entered zero on OIR's public website in order to avoid revealing rate hikes to competitors prior to the Jun 27th reporting deadline. (OIR took the website off-line after the practice was publicized by *Health News Florida*.)

OIR states that the proposed rates showed a mix of increases and decreases and will be fully released in late July. OIR cannot modify or reject any rate hikes because that authority was removed from them for two years by the Republican-controlled legislature, which requires OIR to attribute any increases to the ACA.

As a result, federal officials will be reviewing rates for Florida's federally-facilitated Marketplace until 2016. However, under the ACA, federal officials can only require insurers to provide the actuarial justification for any double-digit rate hikes and release them to the public (see Update for Week of August 29, 2011). It remains to be seen whether Florida insurers can use the state's trade secret law to protect against public disclosure of actuarial data supporting the rate hikes.

Twelve insurers submitted rate filings prior to the deadline, up from 11 that participated in the Marketplace for 2014. Florida Blue HMO and Florida Health Care Plans have elected to no longer participate. However, UnitedHealthcare, Time Insurance Company, and Health Options are planning to participate for the first time in 2015.

Georgia

Blue Cross and Blue Shield to gain statewide competition for Marketplace consumers

Insurance Commissioner Ralph Hudgens (R) revealed last week that insurers participating in the federally-facilitated health insurance Marketplace for Georgia will see greater competition in 2015.

CIGNA, Coventry, Time Insurance, and United Healthcare are seeking to join the five holdover participants from the inaugural open enrollment period. Coventry and Time Insurance will offer Marketplace plans in every Georgia county. Only Blue Cross and Blue Shield (BCBS) of Georgia did so in 2014, causing a wide disparity in premiums from metro Atlanta to rural counties. This resulted in southwest Georgia counties to trail only mountain resorts in Colorado for the nation's highest Marketplace premiums (see Update for Week of November 11th).

The competition has compelled BCBS to lower its Marketplace premiums by an average of seven percent (with cuts ranging from 3.1 to 14.6 percent). The other four holdovers (Alliant Health Plans, Humana, Kaiser Permanente, and Peach State Health Plans) are proposing modest hikes. Humana, which had the lowest Marketplace premiums for 2014, is seeking a nine percent average increase.

Three insurers (BCBS, Kaiser, and Alliant) plan to offer coverage in the small group Marketplace.

Hawaii

Legislation expanding Marketplace oversight, removing insurer representation becomes law

S.B. 2470 became law this week without the signature of Governor Neil Abercrombie (D). The measure increases state oversight of the Hawaii Health Connector Marketplace created by the Affordable Care Act (ACA), which was beset with technological glitches that delayed the start of 2014 open enrollment (see Update for Week of October 21, 2014).



In addition to creating a new legislative oversight committee, S.B. 2470 requires annual audits, allows approved agents and brokers to directly enroll consumers into qualified health plans, and reduces the members of the governing board from 15 to nine by removing all representatives of health insurers.

Despite early versions converting the Connector to a state agency, it remains a non-profit corporation (see Update for Week of March 10th).

Massachusetts

Governor signs biosimilar substitution bill into law

Massachusetts became the eighth state last week to enact legislation enabling pharmacists to substitute a biosimilar for a branded biological product.

The Affordable Care Act (ACA) created a new regulatory pathway for less-costly biosimilar copies of existing biologics. However, the Food and Drug Administration (FDA) has yet to implement regulations that would allow for approval and is in the process of issuing up to five guidance documents this year.

Groups representing brand-name manufacturers have pursued legislation in at least 15 states that restricts when biosimilars can be substituted for the reference biologic (see Update for Week of September 3rd). However, the law signed by Governor Deval Patrick (D) imposes only limited restrictions, such as requiring the pharmacist to notify the prescribing physician and patients of any biosimilar substitution and barring any substitution if the physician does not approve.

The Generic Pharmaceutical Association praised the Massachusetts law for not imposing more burdensome restrictions than were enacted by other states (see Update for Week of September 3rd).

Massachusetts joins Delaware, Florida, North Dakota, Utah, Indiana, Oregon and Virginia as states that have adopted a biosimilar substitution law. However, ten states have rejected comparable legislation (see Update for Week of October 14th).

Missouri

Governor vetoes renewed navigator restrictions

Governor Jay Nixon (D) vetoed legislation last week that would have limited who could serve as a navigator helping to facilitate enrollment in the federally-facilitated Marketplace (FFM) operated in Missouri pursuant to the Affordable Care Act (ACA).

The legislation (S.B. 508) required examination, fingerprinting, backgrounds checks, and licensure for any entity seeking to operate as a navigator and excluded anyone convicted of a felony or misdemeanor involving fraud or dishonesty.

The measure was based on model legislation pushed in more than 20 states by the conservative American Legislative Exchange Council (ALEC) that opposes the ACA. The Governor vetoed S.B. 508 based on a drafting error in the model legislation that cited an inapplicable federal law, which was uncorrected in S.B. 508 despite being corrected in state navigator laws passed by Arizona and Louisiana.

Bill sponsor Senator Mike Parson (R) pledged to renew the legislation next session. A federal court in Missouri had invalidated Missouri's earlier effort to impose more draconian restrictions on navigators that effectively prevented them from carrying out their duties under the ACA, holding that FFM states could not impose any more restrictive requirements than those set forth in the ACA statute (see Update for Weeks of January 20th and 27th). However, the Obama Administration has subsequently issued regulation allowing FFM states to require licensure, background checks, fingerprinting, and examinations, so long as they do not interfere with a navigator's proscribed duties (see Update for Week of June 2nd).



New York

Insurers seek 13 percent average rate hike for individual market

According to initial rate filings posted last week by the Department of Financial Services (DFS), the state's 41 individual market insurers are seeking an average increase of 13 percent for 2015. The average includes a mix of rate hikes and cuts, with the six most popular plans seeking a 14.6 percent average increase while UnitedHealthcare is seeking nearly a six percent average decrease.

Among the 16 insurers participating in the NY State of Health Marketplace created by the Affordable Care Act (ACA), the non-profit cooperative created with ACA loans that surprisingly garnered the highest market share (40 percent) due to low 2014 premiums will seek a 15.2 percent average increase. Health Republic blamed increasing medical costs and utilization, as well as declining support from the temporary ACA reinsurance program that reimburses insurers for exceptional claims costs.

If DFS approves Health Republic's request, the monthly premium for the most generous platinum level coverage would climb from \$409 to \$475, while silver plans upon which premium tax credits are based would jump from \$308 to \$330 but still be among the lowest in the Marketplace. (The price of catastrophic plans would actually fall from \$172 to \$151 per month.)

Fidelis, which captured the second largest individual Marketplace share at 17 percent, is seeking a 7.1 percent increase, which it attributes to an older than anticipated pool of subscribers in 2014.

MetroPlus, which offers Marketplace plans only to New York City customers (where it garnered 44 percent of the market) is seeking an 18.5 percent average increase, which could dramatically increase premiums on platinum plans from \$457 to \$585 (though likewise cut catastrophic premiums).

Empire Blue Cross and Blue Shield, which captured only 14 percent of the Marketplace, will likewise raise rates by an average 18 percent, with silver plan costs rising from \$488 to \$571 per month.

Emblem Health, which captured nine percent of the individual Marketplace is seeking an average 9.5 percent rate increase. However, this would increase platinum plan premiums to an average of \$687, while silver plans would jump to \$466.

MVP (with only eight percent of the individual Marketplace in 2014) requested a whopping 19 percent increase, claiming that it greatly underestimated the cost of care in New York City as well as the value of certain benefit plans and the expected impact of the Federal Risk Transfer Program between carriers. Their average cost for a silver plan would jump from \$403 to \$466 per month.

The 13 percent average increase sought by insurers for 2015 is significantly greater than the 9.5 percent sought in 2014. However, DFS approved only a 4.5 percent average increase for all individual plans last year and is likely to again reduce proposed rates for the upcoming year.

South Dakota

Wellmark to stay out of ACA Marketplace, increase rates on ACA plans by nearly 15 percent

South Dakota's dominant health insurer filed proposed 2015 premiums this week, seeking to increase rates by nearly 15 percent for individual plans that comply with the Affordable Care Act (ACA).

Wellmark Blue Cross and Blue Shield has already decided that it will continue to offer non-ACA compliant individual plans until 2016 consistent with the discretion granted by the Obama Administration which allowed extensions until 2017 (see Update for Week of March 3rd). It will not seek more than a 7.9 percent increase on these non-compliant individual plans and no increase for non-compliant small group plans. The insurer will seek only a 2-4 percent increase on small group plans that comply with the ACA.



Wellmark also backtracked on earlier plans to participate in the federally-facilitated Marketplace (FFM) for South Dakota in 2015 and decided to sit out for one additional year. Despite not participating in 2014, Wellmark sold more ACA policies than any other carrier in South Dakota.

Three small insurers that participated in the initial Marketplace (Avera, Sanford and Dakotacare) all plan to return for 2015. They enrolled less than 14,000 consumers combined through April 2014. Due to the limited competition, the average monthly Marketplace premium before tax credits was \$372 in 2014, well above the \$346 average for the 36 states with FFMs.

Virginia

Republican lawmakers agree to special session on Medicaid expansion

Republican leaders announced this week that they will call the House and Senate back into special session in late September to renew debate on stalled Medicaid expansion initiatives.

Republicans used their newly-acquired control of the Senate last month to kill all proposed provisions of the state budget that would participate in the Medicaid expansion under the Affordable Care Act (see Update for Week of June 9th). Governor Terry McAuliffe (D), who was elected last fall on a pledge to expand Medicaid, has promised to pursue the expansion administratively, after vetoing a Republican-backed provision in the enacted budget that would prohibit any expansion without legislative approval. His Health and Human Resources Secretary is expected to announce the Governor's plan by September 1st.

By extending the special session that the Governor called last spring, House Speaker William Howell (R) and Senate Majority Leader Thomas Norment (R) are seeking to reaffirm their commitment to debate the issue if it was divorced from the budget process. By insisting that Medicaid expansion be part of the budget for the coming fiscal year, Democratic leaders had created an impasse that threatened to shut down the government on July 1st (see Update for Week of March 10th).

Moderate Senate Republicans had supported a "private-sector" alternative to the Medicaid expansion, similar to the federally-approved model for Arkansas, Iowa, and Michigan where ACA matching funds are used to instead purchase private Marketplace coverage for the upper-end of the newly-eligible population (see Update for Week of December 9th).