



Health Reform Update – Weeks of August 25 and September 1, 2014

CONGRESS

Full appellate court to review panel decision invalidating federal Marketplace subsidies

The District of Columbia Circuit Court of Appeals announced this week that it has granted the Obama Administration's request to rehear a three-judge panel decision invalidating Affordable Care Act (ACA) subsidies offered in the federally-facilitated Marketplace (FFM).

Two of the three Republican-appointed justices on the panel previously held that the text of the ACA statute allows the premium tax credits to be offered only in state-based Marketplaces (SBMs). However, a separate Fourth Circuit panel of three judges appointed by Democrat presidents ruled that when the applicable provision is not pulled out of context, the ACA statute clearly intended to offer the subsidies to both FFM and SBM consumers (see Update for Week of July 21st).

If partisan divisions continue to hold, the full District of Columbia court is likely to uphold the subsidies, as eight of the 13 judges were Democratically-appointed. Oral arguments are set for December 17th.

Two other analogous challenges remain pending in Oklahoma and Indiana (see Update for Week of August 11th). If a split in opinions remains after all are final, the U.S. Supreme Court will typically agree to hear them.

Senate Republicans seek updated details on Marketplace enrollment

Senators Lamar Alexander (R-TN) and John Barrasso (R-WY) are asking the Centers for Medicare and Medicaid Services Administrator to provide detailed information next week on the total number of enrollees in Affordable Care Act (ACA) Marketplaces.

In a letter sent last week, the Senators want updated figures through August 15th, including breakdowns by state, age, and metal tier. In addition, they asked the Administrator to identify the number of enrollees that failed to pay their first premium.

CMS last provided updates on Marketplace enrollment in May shortly after the end of the inaugural open enrollment period, disclosing that more than eight million had enrolled in Marketplaces nationwide (see Update for Weeks of April 28th and May 4th). However, several million more are believed to have subsequently enrolled in special enrollment periods created by life status changes or technological impediments.

FEDERAL AGENCIES

CMS actuary says out-of-pocket spending to actually decline for 2014

A new report from the chief actuary for the Centers for Medicare and Medicaid Services (CMS) credits the Affordable Care Act (ACA) for slightly reducing out-of-pocket (OOP) spending on health care for 2014, but warns that the decline may represent a "historical aberration" and not a permanent shift.



The 0.2 percent decrease would represent only the third decrease since 1967 and an abrupt reversal from 2013 when OOP spending increased 3.2 percent. The CMS actuary predicts that it will revert back to a 2.3 percent rate of growth for 2015 before peaking at 5.8 percent by 2020. However, OOP spending as a share of overall spending is expected to decline from 11.7 percent in 2013 to 9.9 percent by 2023, despite a 5.4 percent projected increase in health insurance premiums over that time.

The CMS actuary identifies “expanded coverage under the ACA” as a partial explanation for this declining trend, but notes that OOP spending as a percentage of overall spending has been falling “for some time.” However, the actuary still predicts that overall national health spending will continue to increase from 17.2 percent of gross domestic product (GDP) in 2012 to 19.3 percent in 2023, despite a lower rate of growth (5.7 percent compared to 7.2. percent from 1990-2008).

The largest driver of health spending will continue to be prescription drugs, which the actuary predicts will increase by 6.8 percent in 2014 and another 6.4 percent in 2015 (more than the 5.6 percent jump in total health spending). The actuary blames costly new drugs like the \$1,000 per pill Hepatitis C drug Sovaldi for the increase, as well as more generous drug coverage available under ACA-compliant health plans.

According to estimates released last week, the Congressional Budget Office (CBO) is also downgrading their projection of Medicare and Medicaid costs, now predicting that the two programs will cost taxpayers \$89 billion less over ten years than the non-partisan scorekeeper predicted last spring (see Update for Week of April 14th). CBO cited the Affordable Care Act (ACA) and ongoing budget sequester as the two primary factors leading to their cost revision.

Despite the slowdown in Medicare and Medicaid spending, CBO warned that total spending on major health care programs is still expected to increase by roughly nine percent in 2014 (or \$67 billion). Medicaid will account for the largest increase of about 15 percent (or \$40 billion). ACA subsidies represent \$17 billion of this amount while Medicare costs make up \$12 billion.

Treasury waffles on whether repayment cap will protect ineligible Marketplace consumers

The Department of the Treasury issued conflicting statements this week on whether federally-facilitated Marketplace consumers that fail to verify their immigration status or income by September 5th will be forced to repay the entire amount of any advanced premium tax credits that they received.

Treasury and the Department of Health and Human Services (HHS) had sought proof of citizenship and income documentation from nearly 310,000 consumers in response to investigations by the Government Accountability Office (GAO) and others showing that the FFM was unable to verify eligibility for most applicants (see Update for Week of August 11th). Those who fail to meet the September 5th deadline will lose coverage as of September 30th.

Congress limited the amount of subsidy repayments to \$300--\$2,500 per year (based on a sliding scale) for those whose income may fluctuate above or below the eligibility threshold (100-400 percent of the federal poverty level). Agency officials initially indicated in press reports that these repayment caps will only protect those that were eligible for a portion of the year. Those determined to have never been eligible for the premium tax credits are not protected by the caps, and will have to pay the entire amount.

However, later in the week the agency clarified that it was reconsidering and the cap may still apply to those who were never eligible. Written guidance on the issue has yet to be issued by Treasury.

Several state-based Marketplaces have voluntarily followed the FFM example. This includes the largest Marketplace in California, which is seeking citizenship verification for 98,000 Covered California consumers by September 30th, but has only received responses from roughly 8,000 (with 6,000 providing



incomplete data). It is not clear if SBMs will have to follow Treasury's lead on capping repayments for those declared ineligible.

Congress had originally limited the subsidy recapture amount to \$400 per family, but later increased the cap \$2,500 per family as a way to offset the 2010 Medicare physician payment fix and later to help cover the costs of repealing the ACA's Form 1099 reporting provision (see Week of April 4, 2011).

HHS will offer early launch of small business Marketplace in five states

The Department of Health and Human Services (HHS) announced this week that it will launch the federal version of the Small Business Health Options Program (SHOP) in five states during the month before the November 15th start of open enrollment for 2015.

Small businesses in Delaware, Illinois, Ohio, Missouri, and New Jersey will be able to start creating accounts, selecting brokers, verifying eligibility, and uploading a roster of workers prior to November 15th. However, they will have to wait until full online functionality starts before they can shop for plans, compare prices, and enroll.

The so-called "soft launch" in five states is an effort to identify and correct any of the technological glitches that plagued the rollout of the FFM for individual plans last fall (see Update for Week of November 11th).

The federally-facilitated SHOP (FF-SHOP) was delayed for one year and will be operated in at least 32 states that have elected not to create their own version (see Update for November 18th – December 6th). However, 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.

Maryland, Mississippi and Oregon are three additional states that plan to create their own SHOP Marketplaces for the 2015 plan year.

HHS 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).

CMS finalizes rule on auto-renewal for federal Marketplace coverage

The Centers for Medicare and Medicaid Services finalized regulations this week that will allow for automatic re-enrollment of consumers in the federally-facilitated Marketplace (FFM).

Proposed regulations indicated that the auto-renewal feature is expected to be applied to roughly 95 percent of all FFM consumers (see Update for Week of June 23rd). Those earning less than 500 percent of the federal poverty line (FPL) will receive notices from the FFM shortly before the 2015 open enrollment period informing them that to change plans or update their income levels and subsidy amounts, they will need to take the step of notifying federal and plan officials.

If tax returns show that a consumer's income has risen above 500 percent of FPL, the FFM will stop providing subsidies at the end of 2014 and renew the person's coverage. Consumers who believe that they still qualify for subsidies will have to send documentation to the FFM. According to CMS, roughly 100,000 of the more than five million FFM consumers will have to reapply for subsidies.



The final rule makes very few changes to the proposed rules and denies industry requests to delay the auto-enrollment feature until 2016. One change will allow insurers to “follow applicable guaranteed renewability requirements and applicable state law to complete re-enrollment outside the [Marketplace...when] an enrollee cannot be re-enrolled in a plan within the [Marketplace].” The rule declines to adopt a “most similar” standard for re-enrolling consumers in QHPs when theirs is no longer available, stating simply that “we expect that [FFM insurers] select a product that most closely resembles the benefits, network type, and service area of the enrollee’s current product.”

CMS notes that it still needs to evaluate how handle re-enrollment in situations where young adults are enrolled in catastrophic plans or aging out of their parent’s group coverage. These issues will be addressed in future guidance.

The final rule still allows state-based Marketplaces (SBMs) to use the FFM auto-renewal feature or any “alternative procedures approved by [CMS] based on a showing by the [SBM] that the alternative procedures would facilitate continued enrollment in coverage for which the enrollee remains eligible, provide clear information about the process [and] provide adequate program integrity protections.”

CMS agrees to withhold more Open Payments data from September 30th public release

The Centers for Medicare and Medicaid Services (CMS) announced this week that it has agreed to industry requests to temporarily remove records of research grants that drugmakers make to physicians through intermediaries from the Open Payments database.

The database was created pursuant to the physician payment sunshine provisions of the Affordable Care Act (ACA). Manufacturers reported payment data to CMS earlier this year and CMS agreed this week to further extend the time period until September 10th for physicians to protest and seek corrections after initial reviews found nearly one-third of records were erroneous and cannot be publicly released (see Update for Week of August 18th). However, CMS has still refused to budge on industry requests to delay release of the data for six months and reiterated that it will do so on September 30th.

According to ProPublica, CMS has agreed to withhold the payment data on research grants from public disclosure until such time as physicians can fully review them. Industry commentators had insisted that the data could be misleading and harmful to physicians if not provided in an appropriate “context” showing all of the related entities receiving the grant money (see Update for Week of July 28th).

Court requires new lawsuit to challenge extension of Section 340B discounts to orphan drugs

The U.S. District Court for the District of Columbia refused to throw out the interpretive rule recently promulgated by the Health Resources and Services Administration (HRSA) that extends Section 340B drug discounts to orphan drugs used for non-orphan indications.

The court had blocked a substantively identical rule last spring, ruling that HRSA lacked the authority to implement this provision of the Affordable Care Act (ACA) (see Update for Week of June 9th). PhRMA asked the court to likewise invalidate the latest rule, arguing that HRSA could not circumvent the court’s injunction “simply by issuing a ‘new’ regulation with the ‘same effect’ as the one being challenged in court” and relabeling it as an “interpretive” rule (see Update for Week of July 21st).

Judge Rudolph Contreras concluded that the rule was a “new agency action” and not at issue in PhRMA’s initial lawsuit. Thus, PhRMA would have to file a new lawsuit in order to challenge the new rule. The ultimate outcome is far from certain since the judge previously indicated that whether HRSA has the authority to implement the ACA provision as an “interpretive” rule is a “gray area” (see Update for Week of July 14th).

Increases in Marketplace premiums remain in single-digits, due largely to increased competition

Several studies revealed this week that average premium increases for health insurance Marketplaces created pursuant to the Affordable Care Act (ACA) are likely to remain in single digits for 2015, while several urban areas may actually see their rates decline.

Updated figures from Pricewaterhouse Cooper's continue to show that average individual premiums are likely to increase by nearly eight percent nationwide, with 31 states and the District of Columbia reporting preliminary or final rate data (see Update for Week of August 11th). However, PwC acknowledges that this average masks major variations within states or regions. For example, proposed premiums in Arizona ranged from a 27 percent average rate hike to a 23 percent average decrease.

The Kaiser Family Foundation announced this week that pre-subsidy premiums for the second-lowest-cost silver plan sold on the Marketplaces (upon which ACA subsidies are based) will fall an average of 0.8 percent in the largest metro areas for 15 states and the District of Columbia. The Denver metro area is expected to see the largest decrease of 15.6 percent on average (to \$211 per month for a 40 year old non-smoker) followed by Providence at 11.4 percent. Nashville residents will experience the largest increase of 8.7 percent (to \$205 per month) followed by Portland, Oregon at six percent. Lower-cost bronze plans will see premiums rise by an average of 3.3 percent, ranging from a 15.7 percent average decrease in Hartford to a 13.3 percent increase in Baltimore.

A working paper released by one the ACA's prime architects Jonathan Gruber and Northwestern University researchers attributed increasing levels of competition in 2015 Marketplaces for holding premium increases in check. For example, it concluded that 2014 premiums for the federally-facilitated Marketplaces fully or partly operated in 36 states would have been 11 percent lower had all insurers in the 2011 individual market participated in 2014 Marketplaces.

In addition, average premiums for the second-lowest cost silver plans in these states would have been 5.4 percent lower had the nation's second largest health insurer (UnitedHealthcare) participated. UnitedHealthcare has elected to join several additional Marketplaces in 2015 (including Connecticut, Florida, Georgia, and Maryland), although it will still opt-out of the largest Marketplace in California (see Update for Week of July 14th).

The Kaiser study found that the level of competition is increasing or will hold steady in metro areas for all 15 states surveyed. The only exception was Portland, Oregon, where the number of participating insurers will fall from ten to eight.

Arkansas

Average Marketplace premiums to fall by more than two percent

Governor Mike Beebe (D) confirmed this week that insurers participating in Arkansas' state partnership Marketplace operated pursuant to the Affordable Care Act (ACA) have proposed to reduce rates by an average of 2.2 percent for 2015.

The Insurance Department had released an even greater net reduction prematurely on its website last week, leading to speculation about its validity. The Governor clarified that the leaked figures failed to account for the multi-state Blue Cross and Blue Shield option, which lower the weighted average decrease from 3.5 to 2.2 percent. He also emphasized that the figures include proposed rates for insurers participating in the Arkansas Private Option, the state's alternative to the Medicaid expansion under the ACA. The Private Option population was made newly-eligible for Medicaid by the ACA but are



instead covered under Marketplace plans under the model approved by the federal government that has been followed by other conservative-leaning states (see Pennsylvania below).

Critics claim that the overall decrease is distorted because the Private Option population represents more than 75 percent of all Marketplace consumers and is likely creating a healthier and less costly risk pool.

Because Arkansas' Marketplace is a federal-state partnership, the rates must still be approved by the federal Centers for Medicare and Medicaid Services. Neither the Governor nor the Insurance Department initially released any insurer-specific rates for 2015. However, the Department did later confirm that the leaked rates were correct for Qualchoice (five percent average increase) and Celtic (12 percent decrease). However, it disputed figures for Blue Cross, insisting that the Department reduced its proposed eight percent rate hike down to two percent.

California

Legislature fails to act on three bills to limit out-of-pocket costs

Three bills that sought to limit out-of-pocket costs for consumers failed to pass the legislature before last week's deadline, but are expected to be revisited next session.

Insurer opposition stalled action on A.B. 1917, which sought to cap prescription drug cost-sharing at 1/12 of the annual out-of-pocket limit set by the Affordable Care Act (see Update for Week of August 4th). Health Access California and bill sponsor Assemblyman Rich Gordon (D) pledged to pursue the bill in coming sessions until concerns are adequately resolved.

S.B. 1176 (Steinberg), which would have made health plans responsible for tracking out-of-pocket costs for in-network providers and reimbursing consumers that exceed the limit, also failed to move forward. Lawmakers noted that the Department of Managed Health Care has already committed to developing comparable regulations.

A.B. 2553 would have ensured that health insurers must allow for out-of-network care with in-network cost-sharing if timely access to in-network care cannot be provided. It also may be addressed through regulation, since such a policy is already in place for plans regulated at the Department of Managed Health Care (DMHC), though not the Department of Insurance.

The flurry of health-related bills that were sent to Governor Jerry Brown (D) include S.B. 964, which would require DMHC to do annual reviews for timely access and network adequacy separately for Medi-Cal managed care plans, Covered California plans, and other individual market plans. The Governor also must decide by September 30th whether to sign or veto A.B. 2088, which makes limited benefit plans in the large-group market supplemental to comprehensive coverage. This consumer protection already exists in the individual and small employer market and is intended to prevent employers from using a loophole to evade the full intent of the ACA.

However, the bill that received the most attention was A.B. 1522, which would make California only the second state after Connecticut to require that employers offer at least three paid days of sick leave per year to employees. Governor Brown had pledged to sign the bill once it included his requested exemption for home care workers.

Hawaii

Small business Marketplace left with only one insurer

The state's largest health insurer announced last week that it will not participate in the Small Business Health Options Program (SHOP) created by the Affordable Care Act (ACA).



The decision by the Hawaii Medical Service Association (HMSA) to opt-out of the small business Marketplace leaves Kaiser Permanente as the only participating insurer. The lack of competition is very likely to inflate premiums for an individual and small business Marketplace that is already the most costly in the nation.

Hawaii elected to create its own individual and small business Marketplaces under the ACA. However, both have been plagued by software glitches and other technological failures. HMSA stated that the unresolved “technical challenges were so great that they severely impacted the public’s ability to use the site” and drained its finance and staffing resources, impairing its capability to serve other consumers. It noted that 133 patient accounts have vanished since being transferred from the Marketplace to HMSA.

In electing to opt-out, HMSA also pointed out that the need for a small business Marketplace is effectively negated by Hawaii’s long-standing employer mandate. Hawaii is the only state in the nation that obtained an exemption from federal ERISA law enacted in 1974 that prohibits states from regulating employer-based health insurance. Congresswoman Colleen Hanabusa (D) and state Senate leaders have urged the state to seek a comparable exemption from the ACA.

HMSA emphasized that it will continue to participate in the individual Marketplace, despite the cost and technological challenges. Only 10,800 consumers have enrolled in health insurance through the Marketplace, costing taxpayers nearly \$19,000 per enrollee.

Indiana

Marketplace will see dramatic increase in competition for 2015

The Department of Insurance general counsel announced this week that nine insurers will offer nearly 1,000 plan options next year in the federally-facilitated Marketplace (FFM) operated in Indiana. The figures represent a dramatic increase in competition from 2014, when only six insurers offered two-thirds fewer plan options.

The greater competition is likely to lower premiums, as the Urban Institute, Avalere Health, RAND, and other entities have all shown that Marketplace premiums are largely correlated to the number of participating insurers (see above). However, the general counsel warned that lower Marketplace premiums have also been largely the result of narrow provider networks and indicated that Governor Mike Pence (R) may propose legislation for next session that goes further than new federal regulations in ensuring broader networks for 2015 (see Update for Weeks of March 17th and 24th).

Montana

Average Marketplace premiums to increase by only 1.35 percent, due to increased competition

State Auditor Monica Lindeen (D) announced this week that average premiums for the federally-facilitated Marketplace (FFM) operated in Montana will increase by only 1.35 percent for 2015.

The figure is significantly below the eight percent average identified by Pricewaterhouse Coopers in preliminary rate filings for 31 states. The average increase was calculated by an independent actuary hired by her office and attributed largely to the increased competition that should result from adding a fourth participating insurer (Assurant) next year. Blue Cross and Blue Shield of Montana, PacificSource and the new Mountain Health Co-op created with Affordable Care Act loans will all return to the FFM. The latter garnered more than 12,000 consumers in Montana’s FFM (see Update for Week of June 23rd).

Oregon

Cover Oregon creates special enrollment period for those wrongly enrolled in Medicaid



Cover Oregon officials announced this week that 1,400 Oregonians who were incorrectly enrolled in Medicaid by the glitch-plagued Marketplace will be able to sign-up for qualified health plans from August 31st – October 30th.

The special enrollment period (SEP) will be held prior to the November 15th start of open enrollment for 2015. Another 700 Medicaid-eligible consumers that were wrongly enrolled in QHPs will be allowed to remain in their plan but received notices that their premium and cost-sharing subsidies under the Affordable Care Act (ACA) would be terminated starting October 1st.

Cover Oregon is still negotiating with the Centers for Medicare and Medicaid Services (CMS) over whether these 700 consumers will have to refund the entire subsidy amounts they wrongly received.

Cover Oregon to remain semi-independent, for now

The Cover Oregon board voted this week to maintain the health insurance Marketplace's status as a semi-independent public corporation instead being moved within a state agency.

Governor John Kitzhaber (D) had recommended the latter as the "lowest-risk path" to ensuring greater accountability and transparency in the contracting process, after the failure of the state-based Marketplace forced it to temporarily default to federal control (see Update for Week of April 21st). The Governor had signed Republican-supported legislation in 2011 creating the Marketplace as a public corporation in an effort to free it from many state contracting rules. However, the inability of the lead vendor Oracle Corporation to provide any online capability during the inaugural open enrollment period has led to several federal investigations and the removal of key Cover Oregon personnel, as well as calls for greater state oversight (see Update for Week of March 3rd).

Board members stated that they were not prepared to cede all control to a state agency like the Oregon Health Authority, preferring to keep the 156-employee bureaucracy at least until a subsequent vote later this month. They did agree to let state agencies assume control if future performance-based checkpoints were not met.

The Governor's office has already asserted control over establishing and measuring these performance checkpoints, as well as connecting Covered Oregon to the federally-facilitated Marketplace web portal at least for 2015. In addition, the Attorney General is suing Oracle to recover some of the payments for its work on the failed web portal (see Update for Week of August 11th). Oracle countersued this week claiming that state officials are "vilify[ing] the company in the media" through "constant public slander" intended to shift blame for the debacle away from the Governor during his re-election campaign.

Pennsylvania

Pennsylvania gets federal approval for Medicaid expansion alternative

Pennsylvania became the 28th state last week (including the District of Columbia) to agree to participate in the Medicaid expansion under the Affordable Care Act (ACA).

Governor Tom Corbett (R) had proposed an expansion alternative last year that was comparable to the model already federally-approved for Arkansas, Michigan, and Iowa (see Update for Week of January 6th). However, he initially included additional provisions backed by conservative lawmakers including work search requirements and higher cost-sharing that caused his plan to be bogged down in negotiations with the Centers for Medicare and Medicaid Services (CMS).

Faced with a tough re-election challenge, the Governor ultimately agreed to drop or weaken these provisions, allowing to CMS to grant a waiver that will let Pennsylvania use ACA matching funds to cover roughly 600,000 residents made newly-eligible for Medicaid in private managed care plans (unlike Arkansas which enrolls the expansion population in Marketplace plans).



Governor Corbett becomes the ninth Republican governor to participate in the ACA expansion, though that number is likely to soon increase. Indiana Governor Mike Pence (R) is continuing to negotiate with CMS on the terms for his Medicaid expansion alternative that relies largely on health savings accounts, while Utah Governor Gary Herbert (R) is refusing to budge on a similar work search requirement to the one that Governor Corbett ultimately scuttled. Tennessee Governor Bill Haslam (R) announced last week that he would submit his own Medicaid expansion alternative to CMS later this year.

Nine insurers have already applied to serve the expansion population in Pennsylvania, with each committing to offer at least two plans options statewide. Enrollment for January 1st coverage is set to begin on December 1st.

Under the terms of the waiver, the upper end of the expansion population (100-138 percent of the federal poverty level) will be required to pay two percent of their annual income toward a monthly premium, but not until the second year of the program (at which point current copayments will be eliminated and premium discounts offered for healthy behavior such as obtaining annual physicals). Those earning below 100 percent of poverty will continue to pay copayments.

The Governor was not able to secure federal approval for the flat \$25 monthly premium for individuals (and \$35 for families), which critics noted would exceed the cost of some subsidized Marketplace plans. However, the waiver will allow Pennsylvania to introduce an \$8 copayment for non-emergency use of the emergency room (instead of its proposed \$10 copayment).

Individuals who do not pay premiums for more than 90 days will automatically be unenrolled. However, the waiver allows them to re-enroll without any waiting period.

In place of the Governor's proposal to require that enrollees prove they are actively looking for work, the state will receive federal Department of Labor funding to assign recipients a career coach and simply encourage them seek employment. Those that register with the state online job search program will also receive premium discounts. However, the Secretary of Public Welfare claimed that nearly two-thirds of the Medicaid expansion population will be employed but uninsured.

State officials estimated that Pennsylvania will save \$4.5 billion over eight years by participating in the ACA expansion. According to the Urban Institute, \$13.41 in federal matching funds will flow into a state for every \$1 that it invests in Medicaid expansion, in addition to state savings and revenues. This does not include the \$10.6 billion increased cost of uncompensated care that Pennsylvania hospitals would have shouldered over the next ten years had the state not expanded.

Tennessee

Court issues injunction against unreasonable Medicaid application delays

A federal judge granted a preliminary injunction this week ordering Tennessee officials to promptly grant hearings on Medicaid applications that have unreasonably been delayed beyond the 45-day deadline set by federal law.

Three consumer advocacy groups led by the Southern Poverty Law Center filed the class action on behalf of applicants who have incurred major health problems while waiting months for the Medicaid applications to be processed. The plaintiffs accused state officials of deliberately sabotaging the application process in order to "demonize the federal government" and "score [the] political points" needed to justify not expanding Medicaid (see Update for Week of July 21st). The lawsuit was filed on the heels of a letter from the Centers for Medicare and Medicaid Services identifying Tennessee as the worst state in the nation for meeting the enrollment guidelines set forth by the Affordable Care Act (see Update for Week of July 14th).



Judge Todd Campbell, an appointee of President Clinton serving on the U.S. District Court for the Middle District of Tennessee, rejected the state's claims that the myriad of changing and confusing federal regulations were to blame for the delayed applications, ruling that states that voluntarily decide to participate in Medicaid are "required to ensure that applications are adjudicated reasonably promptly." He certified the class action and ordered state officials to provide a fair hearing within 45 days to any applicant that requests one (or 90 days if the person's eligibility is based on a disability).

Washington

Marketplace lowers proposed rate increases to two percent average, adds platinum coverage

The Washington Health Benefit Exchange Board provided final certification last week for the Qualified Health Plans (QHP) that will be offered through the Washington Healthplanfinder during the 2015 open enrollment period starting November 15th.

Following initial approval by the Office of the Insurance Commissioner (OIC), the Board will allow ten participating insurers to offer 82 QHP options for individual and families, up from only eight insurers and 48 plan options in 2014. Plan options will increase for every county, while the highest-tier platinum coverage will be offered for the first time through one insurer (BridgeSpan) in 12 counties.

The board used its authority to negotiate with insurers and exclude higher-cost options to lower proposed rate hikes to an average of only 1.9 percent (down from 8.6 percent). The largest rate hike belongs to Premera Blue Cross, which received approval to hike premiums 2.6 percent for individual plans in and outside of the Marketplace (despite requesting an 8.1 percent average increase). By contrast, Kaiser Health Plan of the Northwest will be forced to cut individual premiums for Marketplace plans by an average of 3.7 percent (despite seeking a 0.75 percent increase). However, the greatest downgrade was applied to Group Health Cooperative, whose 11.2 percent proposed rate hike in and out of the Marketplace was reduced by the board to zero percent.

At least three others insurers (United Healthcare, Northwest Health Plan, and Health Alliance) are still under review by OIC and may be added at a later date.

The small business Marketplace will be available for the first time statewide through Moda. One other insurer (Kaiser Health Plan) will offer coverage in two counties. Together they will provide small businesses with 23 different plan options.

Eight additional multi-state plans must be certified by the U.S. Office of Personnel Management (OPM) before they can be offered through the Healthplanfinder.

Healthplanfinder officials also announced this week that nearly 11,500 consumers have enrolled in QHPs since open enrollment closed on March 31st. These individuals had qualifying life events triggering a special enrollment period. Overall, the Healthplanfinder has now enrolled more than 1.28 million consumers in health insurance coverage, with more than 147,000 purchasing QHP coverage.

Healthplanfinder officials reported that while more than 8,000 QHP consumers receiving ACA subsidies have transitioned to Medicaid coverage since open enrollment closed, this type of "churn" represents "normal fluctuations of any health insurance risk market." However, they acknowledge that more than 8,300 QHP subscribers have also been dis-enrolled due to nonpayment of premiums.

Wisconsin

CMS grants special enrollment period for Medicaid enrollees whose coverage was terminated

The Centers for Medicare and Medicaid Services (CMS) agreed this week to create a special enrollment period (SEP) in the federally-facilitated Marketplace (FFM) for Wisconsin residents whose



Medicaid coverage was terminated under the partial expansion plan enacted by the Republican-controlled legislature.

The expansion plan sought by Governor Scott Walker (R) allowed about 97,500 childless adults earning up to 100 percent of the federal poverty level (FPL) to become Medicaid-eligible but lowered the overall eligibility threshold from 250 to 150 percent of FPL, eliminating coverage for about 63,000 residents (see Update for Week of November 11th). The plan was not federally-approved as it does not extend Medicaid coverage to everyone earning up to 138 percent of FPL, causing Wisconsin to forgo ACA matching funds and more than \$206 million in savings during 2014 and 2015 (see Update for Week of August 18th).

U.S. Senator Tammy Baldwin (D-WI) had asked CMS to create a SEP for these residents, as they lost coverage due to “unique circumstances” that were outside their control. CMS agreed to give them until November 2nd to obtain coverage through the FFM operated in Wisconsin.

Senator Baldwin noted that only about 40 percent of those who lost Medicaid coverage were able to enroll in the FFM during the inaugural open enrollment period, well below the 90 percent estimated by the Walker Administration.