



Health Reform Update – Week of September 15, 2014

CONGRESS

Congress avoids government shutdown with temporary spending bill

Showing no appetite for a repeat of last year's government shutdown, both the House and Senate overwhelmingly approved a temporary stopgap spending resolution this week that funds the federal government at current levels from the September 30th fiscal year end until December 11th.

The measure (H.J. Res 124) is expected to be signed by President Obama. It cleared both chambers without any of the rancorous debate over defunding or repealing the Affordable Care Act (ACA) that impeded spending resolutions in previous years (see Update for Week of September 30, 2013). Members of both parties wanted to be able to campaign without interruption for the next seven weeks and not return until after the midterm elections.

Negotiations for a full-year spending resolution were expected to be simplified by the budget agreement last winter that froze discretionary spending for fiscal years 2014 and 2015 (see Update for Week of January 13th). However, the ability of the lame-duck session to pass any legislation in December may rest on whether Republicans gain control of the Senate starting in January. Recent polls show they currently have better than 50-50 chance of doing so, dependent largely on whether turnout for the midterms exceeds the typically low expectations for a non-Presidential election.

House Republicans also passed legislation (H.R. 4) that includes a repeal of the medical device tax imposed by the ACA and increases the 30 hour per week threshold for the law's employer mandate. However, neither the Senate nor the President has agreed to even consider the measure.

GAO warns that federal web portal remains vulnerable to online attacks

A new report from the Government Accountability Office (GAO) warned this week that the web portal for the federally-facilitated Marketplace (FFM) remains vulnerable to online hackers despite stepped-up efforts by the Obama Administration to prevent security breaches.

The non-partisan watchdog recommended that the Department of Health and Human Services (HHS) take six major actions and 22 technical improvements to secure private consumer information linked to www.healthcare.gov, including income and citizenship data. HHS only agreed with half of GAO's recommendations.

The federal web portal was used by nearly 5.5 million consumers in 36 states during the inaugural open enrollment period. While the portal was revamped last November following technical glitches that plagued the initial rollout, it has functioned largely above expectations since that time.

However, HHS did acknowledge earlier this month that it had to disconnect certain servers and further upgrade security standards after malicious software was found. GAO specifically criticized HHS for failing to diligently enforce stronger password requirements, oversee security precautions put in place by contractors, and create an alternate site in the event of a disruptive attack. (HHS claims that it is working with Hewlett Packard on creating such a back-up site, but not until next year.)

The House Government Reform and Oversight Committee held a hearing this week to discuss the security issues with officials from GAO, HHS, Homeland Security, and other agencies.



CMS tells Congress that 90 percent of Marketplace consumers have paid premiums

The Centers for Medicare and Medicaid Services (CMS) Administrator informed Congress this week that roughly 7.3 million Marketplace consumers have paid plan premiums as of August 15th, representing 90 percent of those that had selected a plan before the close of the inaugural open enrollment period last spring.

CMS had previously been unable to provide Congress with details on how many individuals actually paid premiums—a sore spot with leaders of the House Oversight and Government Reform Committee. However, the Administrator did not have additional details sought by the committee, including an estimate of how many of the 700,000 consumers that dropped coverage since May did so due to non-payment of premiums.

The agency is expected to shortly release updated figures on how many individuals have enrolled in coverage through the Medicaid expansion under the Affordable Care Act (ACA). CMS previously reported that at least 7.2 million more individuals were enrolled in Medicaid and the Children's Health Insurance Program in June compared to the opening of the Marketplaces last October (see Update for Week of August 4th).

FEDERAL AGENCIES

CDC survey shows uninsured rate has hit a new low

The Centers for Disease Control and Prevention (CDC) announced this week that the number of uninsured Americans is now at its lowest level since the agency started recording such data in 1997.

The CDC's National Health Interview Survey of more than 27,600 adults under age 65 during the first three months of 2014 found that the number without health insurance dropped to 18.4 percent, a full two percent decline from 2013. Among all ages, the uninsured rate fell from 14.4 to 13.1 percent (more than two percent lower than figures initially reported in 1997).

Researchers stress that the actual figure is likely much lower, since the survey ended in March. As a result, it did not include the majority of the eight million consumers that enrolled in Affordable Care Act (ACA) Marketplaces, since most signed up during the last month of open enrollment (see Update for Week of April 14th).

The most pronounced drop occurred among young adults, whose uninsured rate fell from 26.5 percent in 2013 down to 20.9 percent. However, researchers attribute both the Medicaid expansion and the Children's Health Insurance Program (CHIP) for most of the overall reduction. They noted that the uninsured rate fell far more precipitously in expansion states (down three percentage points to 15.7 percent) compared to opt-out states (down one percentage point to 21.5 percent). CHIP had also cut the rate of uninsured among children by half even prior to ACA implementation.

The results roughly match earlier findings by organizations like Gallup, the Kaiser Family Foundation, and the Urban Institute. For example, Gallup's most recent survey of 45,000 adults during the second quarter of 2014 found that the overall uninsured rate stood at 13.4 percent (see Update for Weeks of June 30th and July 7th), with a similar disparity among expansion and opt-out states.

OIG warns that copayment coupons are improperly being used for Part D drugs

The Office of the Inspector General (OIG) for Health and Human Services (HHS) issued a new report and supplemental advisory bulletin this week warning that copayment coupons provided by drug



manufacturers are being improperly used by Part D enrollees for covered drugs, despite company safeguards.

The federal anti-kickback statute prohibits manufacturers from inducing the purchase of drugs covered under federal health care programs via the “knowing and willful offer or payment of remuneration.” The new OIG guidance reiterates that manufacturers risk sanctions if they “fail to take appropriate steps to ensure that their copayment coupons do not induce the purchase of....drugs paid for by Medicare Part D.”

OIG acknowledges that manufacturers have put several safeguards into place to prevent copayment coupons from being improperly used to purchase Part D drugs. However, their surveys of 30 manufacturers producing the top 100 branded drugs in Part D found that 6-7 percent of Part D enrollees were still able to use the coupons to purchase drugs paid for by the program.

The report warns that the use of copayment coupons by enrollees could substantially raise Part D costs, based on OIG’s conclusion that they encourage enrollees to choose brand-name drugs over less costly alternatives.

CMS concurred with OIG’s recommendation that the agency “cooperate with industry stakeholder efforts to identify a solution to prevent coupons from being used to purchase drugs paid for by Part D.” OIG specifically warned CMS and stakeholders to “improve the reliability of pharmacy claims edits that facilitate verification of Part D enrollment and to explore how best to make coupons universally identifiable and transparent in pharmacy claims data.” It identified the inability of Part D plans and other entities to identify coupons within pharmacy claims as a significant vulnerability in existing safeguards that prevents “oversight entities, like CMS and OIG, from monitoring the use of coupons.”

Both the report and bulletin focused on Part D and did not discuss the use of copayment coupons within the health insurance Marketplaces created by the Affordable Care Act (ACA). However, the bulletin did reference prior OIG and CMS guidance documents that recognized the benefit of copayment support from independent charities like PSI, so long as the assistance is provided “without regard for the particular medication a patient may be using” (see Update for Week of June 2nd). Despite this affirmation, CMS has yet to retract a provision in an interim final rule that appeared to contradict this position (see Update for Weeks of March 17th and 24th).

CMS threatens to cut-off ACA subsidies this month for 363,000 Marketplace enrollees

The Centers for Medicare and Medicaid Services (CMS) announced this week that it will terminate Affordable Care Act (ACA) subsidies on September 30th for those who do not respond to agency requests within the next two weeks for documentation verifying their income.

The agency found that as of September 14th roughly 363,000 consumers in the federally-facilitated Marketplace (FFM) still have unresolved income-related discrepancies that could jeopardize their subsidy eligibility. This number is but a fraction of the 1.6 million individuals with such discrepancies last May, and the 7.2 million receiving subsidies overall. However, the inability to verify subsidy eligibility remains a potent political argument for ACA opponents that the Administration is anxious to resolve (see Update for Week of July 21st).

CMS had previously warned roughly 966,000 consumers that their FFM coverage would be terminated September 30th if they failed to verify their immigration status (see Update for Week of August 11th). The agency stated this week that roughly 115,000 had still not done so.

CMS notes that individuals who lose their coverage may regain it through a special enrollment period once they prove their lawful immigration status. The agency also stressed that those with income discrepancies will simply lose their subsidies but not their coverage.



Private survey shows most Marketplace enrollees find premiums to be affordable

A new study released this week by The Commonwealth Fund found that most consumers in the health insurance Marketplaces created by the Affordable Care Act (ACA) found their coverage to be “affordable”.

The survey of 4,425 adults taken shortly after the close of the 2014 open enrollment period showed that 61 percent of respondents could afford their plans, with that figure increasing for those receiving ACA subsidies to offset the cost of coverage. Overall, more than 70 percent were confident that they would receive quality health care they could afford, while 68 percent rated their selected plans as good or excellent.

However, the high overall satisfaction contrasted with consumer experiences shopping for coverage. Only 40 percent were satisfied with their shopping experience, while 43 percent said it was “easy” to find at least one affordable plan. While 57 percent reported little difficulty comparing premium costs for different plans, just under 50 percent found it “easy” to compare potential out-of-pocket costs and plan benefits.

The findings showed that partisan allegiances may affect consumer views, as nearly 75 percent of Republicans reported dissatisfaction with their experience, compared to only 52 percent of Democrats. Young adults were also more likely than any other age group to rate their experience shopping for exchange plans as either good or excellent.

HHS says enhanced rate review saved consumers \$1 billion last year

The Department of Health and Human Services (HHS) released a new report this week claiming that the rate review provisions of the Affordable Care Act (ACA) lowered health insurance premiums by more than \$1 billion in 2013.

Since 2011, the ACA has required that individual and small group plans provide actuarial data justifying any double-digit premium increase (see Update for Week of August 29, 2011). State and federal regulators used this data to publicly “shame” insurers whose rate hikes were deemed “unreasonable” because they went beyond legitimate increases in medical costs. The ACA also provided states with federal grants to strengthen their own rate review processes and make them more transparent to the public.

The report shows that rate hikes in both the individual and small group markets have consistently been below the amounts requested by insurers and typically limited to single digits, instead of the double-digit rate hikes that were common in both markets prior to the ACA. The results mesh with other studies by PricewaterhouseCoopers and Avalere Health, which found that early rate filings indicate premium increases next year will average roughly 7-8 percent and actually decline in several states (see Update for Week of September 8th).

According to HHS, \$703 million of the \$1 billion in 2013 savings came from the small group market. Combined with consumer refunds mandated by the ACA’s new limit on insurer profits, consumers have saved more than \$2.8 billion in both 2012 and 2013.

HHS used the report to announced it was extended \$25 million more in rate review grants to 21 states, including California, Maryland, Massachusetts, New Jersey, Oregon, Washington, and Wisconsin.

Medicare Advantage enrollment to reach all-time high despite ACA “cuts”



Medicare Advantage (MA) plans remain popular a rise in premiums and “cuts” mandated by the Affordable Care Act (ACA), according to new figures released this week by the Centers for Medicare and Medicaid Services (CMS).

Average premiums for the private managed care plans that provide supplemental benefits will increase by \$2.94 per month to \$33.90 for 2015. However, CMS emphasized that premiums will not increase for 61 percent of MA enrollees.

CMS also projects that plan enrollment will climb by another 3.17 percent to just over 16 million in 2015, for a 42 percent increase since the ACA was implemented in 2010. The figures represent an all-time high and appeared to rebut claims by ACA opponents that restricting the rate of growth in MA payments would decimate the program. These “cuts” prevent MA payments from exceeding fee-for-service payments, in response to studies by the Government Accountability Office, Medicare Payment Advisory Commission, and other entities concluding that CMS was overpaying MA plans.

CMS announced last spring that it would raise its average reimbursement for MA plans by 0.4 percent, even though insurers insisted that payments were effectively declining by at least three percent (see Update for Week of April 7th). CMS estimates that from 2010-2015, MA plans will see an overall reimbursement decrease of six percent due to this ACA restriction.

An Avalere Health review of the CMS data found that although many of the MA plans are continuing to offer plans with low premiums, they are increasing out-of-pocket costs for enrollees. The consulting firm found that among the five insurers that capture 40 percent of all MA enrollment have premiums below \$30 per month, most plan options now require enrollees to pay the standard \$320 deductible (instead of no deductible) and three-quarters no longer provide coverage in the Part D “doughnut hole”.

Accountable care organization demonstrations reap \$372 million in Medicare savings

The accountable care organization (ACO) demonstrations created by the Affordable Care Act (ACA) have saved Medicare more than \$372 million since its 2012 implementation, according to performance data released this week by the Centers for Medicare and Medicaid Services (CMS).

Final CMS regulations allow physicians, hospitals, and other providers to share the savings if they collaborate to meet certain targets to limit duplicative tests, needless procedures and other inefficiencies caused by Medicare's fragmented payment system (see Update for Week of October 17, 2011).

According to CMS, about a quarter of the 243 ACOs in the Pioneer ACO Model and the Medicare Shared Savings Program performed well enough to qualify for \$445 million in these “bonuses”. Their average score for quality of care has increased from 71.8 percent in 2012 to 85.2 percent in 2013.

The final rules protect most ACOs from penalties if they slightly exceed targets (which 41 did). However, four ACOs overspent significantly and actually owe money to CMS (up to \$4 million for one group). When accounting for these inefficient ACOs, the total savings come out to \$372 million.

FDA publishes “purple book” for biologic and biosimilar drugs

The Food and Drug Administration (FDA) published a first-time list this week of all brand-name biologic products, including any biosimilar copies that are interchangeable with the reference product.

The so-called “Purple Book” is similar to the Orange Book for small molecules. However, unlike the searchable version of the Orange Book, the Purple Book currently exists only as simple spreadsheets in PDF form. The FDA is also not legally obligated to publish the Purple Book, as it is the Orange Book.



Only two companies (Sandoz and Celltrion) have submitted a biosimilar application under the new approval pathway created by the Affordable Care Act (see Update for Week of July 28th).

STATES

Alaska

Only one of two Marketplace insurers will extend ACA-deficient plans

Moda Health announced late last week that it will not offer Marketplace plans for 2015 that fail to comply with the new consumer protections required by the Affordable Care Act (ACA).

The Division of Insurance allowed health plans to extend the ACA-deficient policies through 2016, consistent with the discretion the Obama Administration gave all states in response to the cancellation last year of more than five million individual plans that failed to comply (see Update for Week of March 3rd). Both insurers in the federally-facilitated Marketplace operated in Alaska pursuant to the ACA had elected to allow ACA-deficient plans for the 2014 plan year. However, only Premera Blue Cross and Blue Shield will do so for 2015.

Premera and Moda announced last week that they will increase Marketplace premiums by 27-37 percent next year due to unanticipated costs from a small group of enrollees transitioning from the state's closed high-risk pool (see Update for Week of September 8th). Moda expects that refusing to allow ACA-deficient policies will broaden the Marketplace risk pool by forcing roughly 800 healthier and less-costly subscribers to purchase Marketplace plans.

Arkansas

Marketplace delays transition to full state control until 2016

The Arkansas Health Insurance Marketplace Board voted 4-2 this week to delay plans to transition to full state control.

The board had already postponed plans to seek additional federal funding for the change, which would move both the individual and small group Marketplaces away from the federal-state partnership that was initially more politically palatable to the Republican-controlled legislature (see Update for Week of August 18th). However, the board feared that rushing to build the technology infrastructure for the 2016 plan year could result in some of the same backlogs and glitches that plagued several state-based Marketplaces (SBMs) during the 2014 open enrollment period.

The delay means that the earliest that Arkansas will have full state control over the individual version of its Affordable Care Act (ACA) Marketplace is the 2017 plan year. However, the board still opted to create a state-based model for its small group Marketplace in 2016, after its contractor (Public Consulting Group) testified that small group Marketplaces are far easier to design and implement.

Arkansas' state partnership Marketplace (SPM) already covers more than 211,000 consumers, compared to only 60 enrolled in its small group counterpart.

Despite backing an earlier transition to state control, Governor Mike Beebe (D) stated this week that he supports the board's postponement.

California

Advocates file suit to eliminate backlog of Medi-Cal applications

A coalition of consumer advocates filed a lawsuit this week seeking to require the Department of Healthcare Services to comply with federal law regarding timely processing of Medicaid applications.



Roughly 2.2 million Californians were added to Medi-Cal during 2014 as a result of the Medicaid expansion under the Affordable Care Act (ACA). DHS officials acknowledge that they prioritized Marketplace applications after the web portal was beset with technical flaws and glitches during the early part of the inaugural open enrollment period (see Update for Weeks of April 28th and May 5th). This resulted in more than 900,000 Medi-Cal applications being delayed past the federally-required 45-day time limit, by far the largest backlog in the nation.

California was one of 12 states that were warned by the Obama Administration last summer to promptly address their backlog of Medicaid applications (see Update for Week of July 14th). DHS did cut the backlog down to 350,000 applications by midsummer. However, consumer advocates insist that the agency should have to notify all applicants whenever their application is not expected to be processed within the 45-day window and grant them any requested hearing. In addition, the lawsuit asks the court to make temporary Medicaid coverage available to applicants while they are waiting on a decision.

One of the plaintiffs, the National Health Law Program, prevailed in a similar class-action lawsuit filed in Tennessee, where the court ordered that state to honor any request for a hearing from an applicant that has waited more than 45 days (see Update for Week of August 25th and September 1st).

DHS blamed a lag in adding automation and self-service portals to their computer systems for much of the initial delay. However, the agency now insists that many of the remaining applications are delayed solely because of incomplete or inaccurate information provided by applicants.

Connecticut

Survey shows ACA helped close racial and ethnic disparities in health insurance coverage

A survey of more than 6,000 consumers in AccessHealth CT shows that the Marketplace created pursuant to the Affordable Care Act (ACA) helped reduce disproportionately higher uninsured rates among African-American and Latino residents.

The findings show that 54 percent of the roughly 209,000 residents that signed-up for health insurance through during the Marketplace's inaugural open enrollment period were previously uninsured (including 62 percent of all newly-Medicaid eligible enrollees). However, even higher numbers of African-American and Latino subscribers reported being uninsured in the previous year (68 and 63 percent).

African-Americans and Latinos make up only about 23 percent of Connecticut's population but they participated in the Marketplace at far higher rates (26 percent of those enrolling in qualified health plans (QHPs) and 44 percent of all new Medicaid enrollment). Nearly one-quarter of all previously uninsured residents in Connecticut were Latino.

More than three-quarters of respondents in QHPs used their coverage to access a primary care physicians, while two-thirds of new Medicaid enrollees did so.

A separate report from the Center for American Progress and AAPIData found that Connecticut (as with most other states) also show disproportionate numbers of Asian American enrollment. This group was the most likely of all Americans to enroll in Marketplace plans for 2014. In California, more than 21 percent of Marketplace enrollees were Asian Americans, even though they make up only 11 percent of the population (Washington saw a more limited but similar disparity at 10.3 percent and 7.4 percent respectively).

District of Columbia

Average Marketplace premiums to rise slightly for individuals, fall for small groups



The Department of Insurance, Securities and Banking (DISB) announced this week that it has finalized 2015 premiums for DC Health Link, the state-based Marketplace created pursuant to the Affordable Care Act (ACA).

Four insurers will participate in the individual version of the Marketplace, offering 31 plan options. Eight insurers will offer 196 plans for small businesses. There are a total of 41 new plan options for 2015, but only one of these will be for the individual Marketplace. However, the total number of plan options will fall to 227 (from 301 in 2014) as UnitedHealthcare and Aetna also eliminated some plan options that had little or no enrollment in 2014.

Three of the four insurers downgraded their proposed rates after DISB used their authority granted by the ACA to publicly disclose data justifying any rate hike of at least ten percent. The approved premiums will increase by an average of 2.3 percent for the individual Marketplace, ranging from a 6.1 percent decrease for Aetna Life to a 7.6 increase for CareFirst Blue Choice. Small group consumers will see a two percent average decline, ranging from a 17.2 percent decrease for Aetna Life to a 12.7 percent increase for CareFirst Blue Choice.

Maine

Marketplace premiums to hold mostly steady for 2015

The Bureau of Insurance approved 2015 premiums last week for the federally-facilitated Marketplace (FFM) operated in Maine pursuant to the Affordable Care Act (ACA).

Final premiums remain subject to federal approval. However, the figures released by the Bureau show that FFM consumers are likely to pay roughly the same or less on average than they did in 2014.

Average premiums will hold steady for Maine Community Health Options. The new non-profit cooperative created with ACA loans used low premiums to surprisingly garner more than an 80 percent market share in 2014 (see Update for Week of June 2nd). The start-up will increase premiums on only one low-enrollment plan and that less than one percent hike will be offset by a half percent reduction on its most popular plan.

Anthem Health Plans, the only other participating insurer in 2014, will reduce premiums by 1.1 percent on average, although some customers will see either a 13 percent drop or 12 percent hike.

Harvard Pilgrim Health Care will join Community Health Options and Anthem in the FFM for 2015, offering individual consumers four separate plan options.

Monthly FFM premiums for individual plans will range in 2015 from \$152 for a basic Anthem plan to \$381 for the highest-tier Harvard Pilgrim plan.

Maryland

Marketplace will allow for early window shopping, require staggered rollout

The chair of the Maryland Health Benefit Exchange Board announced this week that consumers seeking coverage in Maryland Health Connection (MHC) will have access to the revamped web portal on November 9th, so that they can start comparing health insurance options and receive subsidy estimates six days before the start of 2015 open enrollment on November 15th.

The move is part of a “staggered rollout” intended to avoid the system crashes and backlogs that plagued the flawed web portal used for the inaugural open enrollment period last fall. Maryland has since replaced that technology with software from Connecticut’s Affordable Care Act (ACA) Marketplace (see Update for Week of August 18th).



The “anonymous browsing” feature will remain in place through the entire open enrollment and let consumers “window shop” without entering any personal information—a main criticism of last year’s version. Consumers can start enrolling in January 1st coverage on November 15th, but only through enrollment fairs. The following day, call centers will start to process applications, while brokers and agents cannot do so until November 17th. Health and social service caseworkers will not have access to the web portal until November 18th and full public access will not start until November 19th.

The board is requiring the roughly 60,000 receiving ACA subsidies for qualified health plans to re-enroll by December 18th in order to continue the subsidies for 2015.

Massachusetts

Marketplace approves 1.6 percent rate hike, extends temporary Medicaid coverage

The board for the Massachusetts Health Connector Board approved a 1.6 percent average premium increase this week for plans participating in the Marketplace for the 2015 plan year.

According to the board’s announcement, the 1.6 percent average increase is roughly half of the 3.1 percent average for all individual plans offered in and outside of the Marketplace. The average premium for a 40-year old living in central Massachusetts will range from \$283 for bronze plans to \$502 for platinum (premiums for the limited catastrophic plans for those under age 30 will average only \$235).

A total of 15 plans will offer 104 plan options to individual consumers (and 22 plan option for the small group Marketplace). UnitedHealthcare will join the 14 other returning insurers from 2014. The board emphasized that all of the insurers have committed to continue offering all standardized plans on their broadest commercial network.

Roughly a quarter of the individual Marketplace plans will be the highest-level platinum tier, while another 40 percent will be gold plans. Only 15 plans will be at the silver-tier (to which Affordable Care Act subsidies are based), while another 14 will be the lowest-level bronze plans. Only ten catastrophic plans will be offered.

There will be no changes in 2015 to the standardized cost-sharing and benefit packages offered in the Health Connector. The deductible for silver and bronze plans will continue to be \$2,000, phasing down to zero for the highest-level platinum plan. All bronze plans and the Gold A option will apply a 50 percent coinsurance to the highest-cost specialty drugs (other Gold B and C plans have only a \$50 copayment). Annual out-of-pocket limits are set at the ACA maximum of \$6,350 for individuals (or \$12,700 for families) for both bronze and silver plans, but phase down to \$1,500 and \$3,000 for the Platinum B option.

The board also announced that it will extend temporary Medicaid coverage for the nearly 300,000 consumers who were unable to enroll through the Marketplace web portal in 2014 due to persistent technical glitches (see Update for Week of July 16th). That software has been entirely replaced for the open enrollment period starting November 15th. However, in order to avoid backlogs from all 300,000 transitioning to Marketplace coverage at the same time, the board will terminate the temporary Medicaid coverage in three phases on January 15th, January 31st, and February 15th.

Minnesota

Largest Marketplace carrier drops out for 2015

Officials with the MNSure health insurance Marketplace created pursuant to the Affordable Care Act (ACA) acknowledged this week that they were caught by surprise when their largest participating insurer opted to drop out of MNSure for 2015.



Preferred One signed-up 59 percent of all MNSure consumers during the inaugural open enrollment period. By offering the Marketplace's lowest premiums, they were able to undercut Blue Cross and Blue Shield of Minnesota, the state's leading carrier. However, analysts blamed Preferred One's "lowball bidding" for the "unsustainable" losses they cited as the reason for leaving MNSure.

The move will force those among Preferred One's roughly 32,500 MNSure customers that are receiving ACA subsidies to switch to plans offered by one of the four remaining Marketplace insurers in order to retain those subsidies for 2015.

MNSure officials emphasized that Preferred One's exit goes against the national trend, which has seen increased Marketplace competition nationwide. A report this month from McKinsey and Co. showed that among the 19 states they surveyed, the vast majority of Marketplace insurers have opted to return in 2015 while 60 percent are increasing their number of plan options. At least 30 new insurers in those states are seeking to enter Marketplaces for the first time.

MNSure had the lowest average premiums nationwide for 2014. MNSure officials conceded that less competition is likely to raise overall premiums in the long run. However, the immediate impact is unclear since the four other insurers have already filed proposed rates for 2015 and will not be able to adjust them to respond to Preferred One's exit before they are finalized by the Department of Commerce.

Mississippi

Marketplace insurers expand offerings for 2015

The two insurers participating in the federally-facilitated Marketplace (FFM) operated in Mississippi announced this week that they are expanding the number of counties they will serve for the 2015 plan year.

Humana, which enrolled roughly 75 percent of the 66,000 FFM consumers for 2014, will increase the number of counties in which they offer plans from 40 to 48. Magnolia Health Plans will add two more counties, meaning that 14 fewer counties overall will be limited to only one insurer (compared to four counties for 2014).

The increased competition is likely to be good news as several studies have shown that premiums are directly correlated to the number of competing insurers (see Update for Weeks of August 25th and September 1st). Mississippi had the second-highest average Marketplace premiums in 2014.

Magnolia Health Plan previously announced that it will reduce Marketplace premiums by 25 percent next year. However, Humana is planning a six percent average rate hike (see Update for Week of August 4th).

Pennsylvania

New bill would prohibit specialty coinsurance for oral anti-cancer drugs

Rep. Matthew Baker (R) introduced H.B. 2471 this week, which would prohibit insurers from placing oral anti-cancer medications on a specialty tier or impose any form of coinsurance that charges subscribers a percentage of the total drug cost. The measure would also ban flat-fee copayments specific to anti-cancer drugs (apart from the minimal copayment usually charged for drugs not placed on a specialty tier).

Vermont

Governor shuts down Marketplace web portal for several weeks

Governor Peter Shumlin (D) ordered the shutdown this week of Vermont Health Connect, in an effort to correct any security flaws prior to the November 15th start of open enrollment for 2015.



The web portal for the health insurance Marketplace created pursuant to the Affordable Care Act (ACA) is expected to be offline for several weeks. In the interim, Marketplace applications and transactions are being processed through the call center.

The move was recommended by the Department of Human Services and Optum, the new contractor brought in last summer to fix ongoing technical failures and glitches that have plagued Vermont Health Connect since it opened last fall. The governor insisted that the shutdown was intended to proactively address concerns about the security of private data on income, citizenship, etc., such as those identified by the Government Accountability Office (see above). He insisted that it was not in response to an actual security breach.

The governor also noted that Optum has already doubled the number of call center personnel and reduced the number of applications requiring income or citizenship verification down from 14,000 to 2,500. Optum took over for CGI Federal, the same contractor largely blamed for the failure of the web portal for the federally-facilitated Marketplace and several other state versions (see Update for Week of June 9th).

In addition to the website shutdown, Governor Shumlin also announced that the Department of Vermont Health Access has been stripped of oversight duties for Vermont Health Connect. Instead, that role will be filled (at least temporarily) by the health reform chief for the governor's office.

Virginia

Republicans promptly reject Medicaid expansion alternatives during special session

As expected, House Republicans blocked a final vote this week on an alternative to the Medicaid expansion under the Affordable Care Act (ACA), even though it was introduced by a fellow Republican.

The measure (H.B. 5008) sought to use ACA matching funds for the expansion to instead cover the newly-eligible population under private Marketplace plans, similar to federally-approved models in four other states. Governor Terry McAuliffe (D) had called for the special session to debate such an alternative (see Update for Weeks of June 30th and July 7th). However, the issue had become so politically divisive that he acknowledged last week that only more limited reforms could currently pass (see Update for Week of September 8th).

Del. Thomas Rust, the Fairfax County Republican sponsoring the measure, pledged to reintroduce it when the regular session convenes in January. It is not clear that it would attract any additional support, as Republicans such as Del. John O'Bannon, a neurologist, insisted that other Medicaid reforms should first be accomplished, such as the Medicaid managed care expansion and higher cost-sharing sought by former Governor Bob McDonnell (R) (see Update for Week of March 10th). However, O'Bannon acknowledged that expansion opponents need to come up with an alternative plan of their own next session, instead of just saying "no".

The House and Senate were able to quickly reach bipartisan agreement this week on a two-year budget now that the Medicaid expansion issue has been divorced from that legislation. Democratic insistence on including Medicaid expansion as part of the budget negotiations nearly shut down the government last summer, before Republicans regained Senate control and ended any practical chances of expansion measures succeeding (see Update for Week of June 9th).