



Health Reform Update – Weeks of October 6 and 13, 2014

CONGRESS

Second lawsuit attempts to block Congress from receiving ACA subsidized coverage

The conservative group Judicial Watch filed a lawsuit in D.C. Superior Court last week seeking to block members of Congress and their staff from enrolling in the small business health insurance Marketplace created by the District of Columbia pursuant to the Affordable Care Act (ACA).

Office of Personnel Management (OPM) regulations required members of Congress and their staff to enroll in the D.C. small group Marketplace if they wished to continue receiving government-subsidized coverage, as had been the case under the Federal Employees Health Benefits Program (see Update for Week of September 30, 2013). More than 12,350 members, staff, and dependents have already done so, making up 85 percent of all enrollees in the D.C. small group Marketplace.

Senator Ron Johnson (R-WI) previously filed a federal lawsuit challenging the OPM regulations, which was dismissed for lack of standing by a Republican-appointed judge (see Update for Week of July 21st). However, the Judicial Watch lawsuit targets the Marketplace itself, insisting that categorizing Congress as a small business violates D.C. law. It insists that by filing in D.C. courts the group can obtain standing to sue on behalf of district taxpayers, whose tax dollars should not be used to subsidize Congressional premiums.

CBO finds that cost of expanding coverage through ACA is lower than original projections

The cost of premium and cost-sharing subsidies provided by the Affordable Care Act (ACA) were far lower in fiscal year 2014 than the Congressional Budget Office (CBO) initially estimated, according to CBO's preliminary report released last week.

According to CBO, the Treasury Department paid \$13 billion in ACA subsidies during the first three quarters of 2014, far less than the \$19 billion that CBO projected in 2010 for the same time period.

Federal outlays for expanding Medicaid under the ACA grew by \$36 billion by the September 30th end of the fiscal year bringing total federal Medicaid spending to \$302 billion, also less than the \$320-335 billion initially projected. Medicare spending was another \$100 billion less than first expected, totaling \$509 billion for FY2014.

The lower figures for ACA, Medicaid, and Medicare spending allowed CBO to also downgrade its calculation of the federal budget deficit to \$486 billion in fiscal 2014. This figure is the lowest since the peak of the recession in 2008 and more than \$195 billion less than the previous fiscal year. However, CBO warns that the deficit is likely to climb again starting in 2016 and reach \$960 billion by 2024, unless Congress takes action to curb future spending growth as "baby boomers" age into Medicare and Social Security.

Lawmakers investigate dramatic price hikes for generic drugs

Two lawmakers are requesting data from at least 14 drug manufacturers justifying a sudden and dramatic escalation in prices for generic medications.

Rep. Elijah Cummings (D-MD), the ranking member of the House Committee on Oversight Committee, and Senator Bernie Sanders (I-VT), chairman of the Senate Subcommittee on Primary Health



and Aging, sent a letter earlier this month to drugmakers in response to a recent analysis from the Healthcare Supply Chain Association documenting that half of all generics sold through retailers became more expensive over the past 12 months. For example, the study noted that the price hospitals and pharmacies pay for 500 tablets of the antibiotic doxycycline spiked to \$1,849 in April, up from only \$20 in October 2013. Likewise, the price for cholesterol-lowering pravastatin rose to \$196 from \$27.

The letter also cited a study by the National Community Pharmacists Association (NCPA), which found that prices paid by pharmacies more than doubled for one out of 11 generics and in some cases exceed 1,000 percent.

Reps. Cummings and Sanders stated that they will wait until responses from the companies are received by October 23rd before deciding whether to hold hearings on the issue.

FEDERAL AGENCIES

CMS streamlines online application process for federal Marketplace web portal

Even though 2015 premium data will not be included until after the mid-term elections, the Centers for Medicare and Medicaid Services (CMS) unveiled an upgraded version of www.healthcare.gov earlier this month, pledging that the streamlined process will reduce application times by half without a repeat of the site crashes and technological glitches that plagued the initial rollout of the web portal last fall (see Update for Week of November 11th).

According to CMS, enrollment applications have been reduced from 76 screens to only 16 and have been optimized so they can now be used on mobile devices. CMS assured consumers that both the website and call centers will now be able to handle "significantly more concurrent users". In an effort to support their claim, CMS stressed that the revamped site has gone through more than five weeks of testing prior to release, compared with a mere ten days last fall.

CMS estimates that roughly 70 percent of new enrollees will be able to use the streamlined application system, while 30 percent will be diverted to the old, lengthier process. The latter will typically be those with children living in their households who are not claimed as dependents on the applicant's federal tax returns.

Critics point out that some flaws from last year remain on the site. For example, CMS will continue relying on the same data sources to confirm user identities, even though difficulties in authenticating online accounts was a major cause of online bottlenecks during the first open enrollment period (see Update for Week of October 21, 2013).

In addition, the Spanish-language version of the web portal continued to have incorrect translations displayed on the home page, despite CMS assurances that they would be fixed. Problems with the Spanish site were among several factors often cited for lower than expected Latino enrollment in year one, even though Latino-Americans are the most likely population to be uninsured.

Two PBM studies confirm Marketplace enrollees are sicker than those with employer plans

Two studies released earlier this month showed that initial consumers in the new health insurance Marketplaces created pursuant to the Affordable Care Act (ACA) were sicker on average than those with employer-sponsored coverage, and more likely to require costly treatment for serious illnesses.

The analyses by pharmacy benefit managers Express Scripts and Prime Therapeutics reviewed prescription drug claims filed during the first half of 2014 and found that rates of filled prescriptions were fairly comparable among Marketplace and employer-sponsored plan subscribers. However, Express



Scripts concluded that Marketplace enrollees were nearly seven years older on average (43.6 years compared to 36.7) while specialty drug costs were ten percent higher for Marketplace consumers (38 to 28 percent).

Affirming earlier findings from last spring, Express Scripts found that Marketplace enrollees that waited until shortly before the open enrollment deadline to enroll were predictably healthier and lower-income. Conversely, those that signed-up towards the beginning of open enrollment were far more likely to have chronic or serious conditions requiring specialty drug therapies (see Update for Week of April 7th).

According to Express Scripts, nearly half of Marketplace consumers already used up their prescription drug benefit by mid-2014. The study cited the fact that Marketplace enrollees fill 59 percent more prescriptions for specialty drugs as a primary reason. This disparity was especially prevalent for Marketplace consumers aged 18-34, who filled nearly twice as many specialty drug prescriptions as comparably aged subscribers in employer plans.

Express Scripts found that three of every five specialty drug prescriptions filled by Marketplace consumers were for HIV medications, documenting the extent to which HIV patients previously helped by AIDS Drug Assistance Programs or left uninsured have migrated to Marketplace coverage. HIV drugs were the most costly prescription drug for Marketplace plans (making up 11.3 percent of all drug spending). By contrast, HIV drugs were not even among the top ten most costly medications for employer-sponsored plans.

Overall, Prime Therapeutics found that drug treatments for HIV and hepatitis C comprised about 18.5 percent of all drug costs for Marketplace enrollees. Spending on these drugs reached 228 and 160 percent of the respective spending for HIV and HCV drugs under employer-sponsored coverage.

CMS posts star ratings for Medicare Advantage and Part D plans

The Centers for Medicare and Medicaid Services (CMS) posted Medicare Advantage (MA) and Part D Star ratings for 2015 last week, which now are accessible via the Medicare Plan Finder during the open enrollment period for both types of plans that runs from October 15th through December 7th.

According to the CMS, MA enrollment is projected to reach a record of 16 million next year. Roughly 60 percent of these enrollees will be in plans that received at least four stars for 2015, compared to 52 percent in 2014 and only 17 percent in 2009.

More than half (53 percent) of all Part D beneficiaries are in stand-alone prescription drug plans for 2015 that received at least four stars, compared to only 16 percent in 2009.

CMS also notes that the number of plans receiving the low-performing icon (LPI) has fallen by 80 percent since 2014. Among those that did not withdraw or consolidate their contracts, 65 percent have improved their star ratings.

The agency recently curtailed a demonstration program created by the Affordable Care Act (ACA) that linked the star ratings to financial bonuses after government auditors, lawmakers, and stakeholders criticized CMS for allowing too many plans to benefit from these payments (see Update for Week of April 7th). A survey by the Kaiser Family Foundation also found that the star ratings largely do not factor into consumer choices of MA or Part D plans (see Update for Week of June 9th).

Medicare Part B premiums to remain flat for 2015

The Centers for Medicare and Medicaid Services (CMS) announced last week that monthly premiums and deductibles for Medicare Part B will remain unchanged for 2015.



Premiums will stay at \$104.90 for beneficiaries with incomes below \$85,000—the same rate as the two prior years—and also remain unchanged for higher income groups that pay more. Part B deductibles also will stay at \$147 (though they will increase slightly for Part A).

The average Medicare Advantage (MA) premium will increase by \$2.94 to \$33.90 next year. However, CMS predicts that the actual 2015 average premium will rise by only \$1.30 because more enrollees are expected to enroll in lower-cost plans.

CMS Administrator Marilyn Tavenner emphasized that the stability in beneficiary costs are due to the continued slowdown in overall Medicare spending subsequent to passage of the Affordable Care Act (ACA). However, economists and researchers have differed on the extent to which the ACA has caused the slowdown.

PhRMA refiles lawsuit challenging HRSA refusal to exempt all orphan drug uses from 340B

The Pharmaceutical Research and Manufacturers of America filed a new lawsuit last week challenging a recent interpretive rule from the Health Resources and Services Administration (HRSA) that fails to extend the Affordable Care Act (ACA) exemption of orphan drugs from mandatory discounts under the federal 340B program when used to treat non-orphan indications.

The trade group was advised to refile the lawsuit by a federal judge, after HRSA issued the interpretive rule in an apparent effort to circumvent an injunction against their earlier rulemaking that the court determined HRSA lacked authority under the ACA to promulgate (see Update for Weeks of August 25th and September 1st). HRSA insisted that by categorizing the rulemaking as “interpretive” it does not create “binding norms and requirements” but is merely a guide for drugmakers. However, PhRMA insists that the agency cannot evade an injunction by simply re-categorizing a rule with no change in its content.

Furthermore, PhRMA contends that the failure to extend the exemption to non-orphan indications contradicts the ACA, because Congress would have written such an interpretation into the law if that were its intent.

Safety Net Hospitals for Pharmaceutical Access and the American Hospital Association have supported HRSA’s interpretation.

The federal 340B program has come under intense scrutiny following government audits warning that it is being converted from a program serving vulnerable populations at safety net hospitals to one that is allowing hospitals and affiliated clinics to reap “windfall profits” (see Update for Weeks of July 1 and 8, 2013). A study by researchers from the University of Chicago and Sloan Kettering Memorial Cancer Center published this month in *Health Affairs* appeared to validate these concerns by documenting that those registered for the 340B program after 2003 served communities that were wealthier and have higher rates of health insurance than in previous years.

HEALTH CARE COSTS

Employer plan subscribers will see modest premiums hikes but greater cost-sharing

The annual employer benefits survey released earlier this month by the Mercer consulting firm shows that consumers in employer-sponsored coverage for likely to see only modest premium hikes for 2015, although companies will continue to shift an even greater share of health plan costs to employees.

The survey data shows that premiums are expected to increase by only four percent on average, far below the double-digit increases seen in years past. However, 68 percent of respondents are increasing employee out-of-pocket costs for 2015, up from 55 percent only two years ago.



Researchers attributed the accelerating shift in out-of-pocket costs to the employer mandate under the Affordable Care Act (ACA), which requires large companies to either provide all workers with minimum essential coverage or pay a per employee assessment. The mandate goes into effect this January for those with 100 or more workers (or 2017 for those with 50-100 workers). In addition, employers are adjusting to the 40 percent tax on so-called “Cadillac” plans (those with premiums that exceed \$10,200 for individuals), which goes into effect starting in 2018.

As part of the shift in out-of-pocket costs, more employees can expect to be offered high-deductible plans (often linked to health savings accounts). A separate survey by Towers Watson and the National Business Group on Health found that nearly three-quarters of employers with more than 1,000 workers now offer such plans, while nine percent more expect to add them in 2015. Roughly 30 percent of these employers plan to limit coverage only to these high-deductible plans, nearly double the percentage from last year.

The Towers Watson survey also found that nearly half of responding employers hiked employee contributions for dependent coverage while 19 percent expect to do so in 2015.

STATES

Medicaid costs are rising less in states that expanded pursuant to the ACA

The Kaiser Family Foundation released a new analysis last week showing that states opting-out of the Medicaid expansion under the Affordable Care Act (ACA) experienced higher spending growth than those that chose to participate.

The report found that overall Medicaid spending grew by an average of 10.2 percent across all states for the 2014 fiscal year that in most states ended on June 30th. Nationwide, states expect Medicaid costs to rise by an average of 14.3 percent for fiscal year 2015. However, average costs are expected to grow by 6.8 percent in the opt-out states versus only 4.4 percent in the 27 states and District of Columbia that chose to expand by June 30th.

Spending growth will be higher in opt-out states even though they are projected to have far lower increases in Medicaid enrollment (only 5.2 percent compared to 18 percent for participating states). Kaiser highlights the higher federal matching under the ACA expansion for the discrepancy, noting that participating states will receive a 100 percent federal match through 2016, phasing down to 90 percent for 2020 and subsequent years. By contrast, the traditional matching rate varies from only 50-73.6 percent in opt-out states.

Most states expanding Medicaid benefits, while specialty drugs top cost-containment efforts

The Kaiser Family Foundation released the results of its latest state survey last week showing a dramatic improvement in state fiscal conditions since the recession of 2007-2009.

The report found that budget deficits have largely abated for three-quarters of all states, compared to the height of the recession where all but a handful of energy-rich states faced major shortfalls. The improving economic climate allowed 22 states to actually expand Medicaid benefits. Only four states (Arkansas, Indiana, Louisiana and Maine) scaled back benefit levels and none plan to do so in fiscal year 2015—the lowest recorded in at least nine years.

Another 14 states are increasing Medicaid reimbursement for specialists in fiscal 2015, while only three are lowering them. However, most states (36) are not voluntarily extending the two-year 40



percent increase in Medicaid payments for primary care physicians that was required by the Affordable Care Act (ACA) through 2014, and 31 states are cutting or freezing Medicaid reimbursement for hospitals.

About 30 states have also elected to experiment with new delivery systems, while 40 plan to do so in fiscal year 2015. The most popular reforms include the use of accountable care organizations that give providers fiscal incentives to collaborate on patient care, as well as the integration of Medicaid and Medicare benefits for people who are dual-eligible.

Despite better fiscal conditions, most states continue to pursue cost-containment measures, with Medicaid managed care expansions near the top of the list. At least 33 states will expand their reliance on the capitated private plans in either fiscal 2014 or 2015 (although Medicaid managed care reimbursement is increasing in most states).

Four states are also increasing premiums on certain higher-income Medicaid enrollees in 2014 and 2015 (while seven are cutting or eliminating them). Federal Medicaid law typically allows nominal premiums to be charged only for enrollees with incomes above 150 percent of the federal poverty level, although several states including Indiana, Tennessee, and Utah are insisting on broader or higher premium levels as part of their proposed “private sector” alternatives to the Medicaid expansion under the ACA (see Update for Week of September 29th).

However, every state is targeting specialty drug costs, in the wake of the Food and Drug Administration (FDA) approval of Hepatitis C “cure” Sovaldi last winter. The \$84,000 price tag per 12-week treatment already forced 22 states to restrict the use of the drug, followed the lead of Illinois and Oregon last summer (see Update for Week of August 4th), and New Jersey is currently weighing competing measures to do likewise.

The FDA’s approval of Harvoni last week is only expected to heighten these concerns, due to the \$94,500 per 12-week treatment cost. Although the manufacturer of Harvoni insists that nearly half of patients may qualify for a shorter and less costly duration of treatment, trade groups warned that Harvoni will essentially replace Sovaldi and be available to an even larger population of Medicaid enrollees.

Researchers at Tufts Medical Center published a study in this month’s *Health Affairs* concluding that despite the disproportionately higher cost of specialty medications like Sovaldi and Harvoni, they tend to provide patients with greater gains in terms of a cost-effectiveness measure called Quality Adjusted Life Years (QALYs). As a result, the study concluded that specialty drugs “may still offer reasonable value for the money.”

Arkansas

Advisory panel seeks broader Medicaid coverage for costly cystic fibrosis drug

The state Drug Utilization Review Board recommended last week that the Medicaid program stop blocking access for a costly drug to treat cystic fibrosis (CF).

Medicaid policy set by the Department of Human Services (DHS) currently requires patients prescribed Kalydeco to first prove their health would not improve by taking two older treatments that cost far less than Kalydeco’s \$311,000 annual price tag (minus the federally-required 23 percent discount). Three CF patients are challenging this policy in federal court (see Update for Week of July 14th).

Arkansas is the only state preventing enrollees from receiving Kalydeco if they meet all eligibility criteria set by the Food and Drug Administration (FDA). DHS defended the policy, insisting that it was not “rationing” because other effective alternatives to Kalydeco are available and clinical data did not yet support the use of Kalydeco as a “first option.” The agency denied that cost was “the determining factor” in forcing enrollees towards the other alternatives, but acknowledged that “how we will pay for [Kalydeco]



is something we must consider [as a] agency with limited funds.” Internal emails provided as part of the lawsuit showing that agency officials termed Kalydeco a “budget breaker.”

Under the revised criteria proposed by the board, enrollees would have to document benefit from Kalydeco in order to coverage to continue, including stabilization or improvement in lung function. Kalydeco approvals and renewals would be made on a case-by-case basis and the documentation requirements would give Medicaid officials “a more complete picture” of patient progress on Kalydeco.

The recommendation of the advisory panel (that includes several physicians) is non-binding. However, DHS immediately announced that it “anticipate[s] adopting the recommendation,” though no timeline was provided.

Attorneys for the plaintiffs in the federal lawsuit remain unsatisfied and pledged to continue the legal challenge even if the revised criteria are adopted.

The lawsuit is being closely watched by consumer advocates for patients with Hepatitis C, as Medicaid programs in several states including Illinois and Oregon have already placed restrictions on coverage for the recently-approved Osvaldo drug that costs \$84,000 per course of treatment (see Update for Week of August 4th).

California

Covered California to drop coverage for 10,000 enrollees that failed to verify immigration status

Covered California officials announced this week that all but about 10,000 of the roughly 100,000 enrollees that were asked to verify their legal immigration status by September 30th were able to do so.

The health insurance Marketplace created by California pursuant the Affordable Care Act (ACA) followed the lead of the Obama Administration that sent similar letters to more than 310,000 consumers in the federally-facilitated Marketplace (FFM) that had discrepancies in citizenship or income data (see Update for Week of August 11th). The move followed audits by the Office of Inspector General for the U.S. Department of Health and Human Services (HHS) and the Government Accountability Office (GAO) that found the FFMs and state-based Marketplaces like California were unable to verify the accuracy of such data in most cases (see Update for Week of July 21st).

Covered California plans to shortly send pre-termination notices to the 9,645 families (representing 10,474 individuals) that failed to verify their lawful status. The notices will include instructions how to reacquire coverage. Final termination notices will ultimately be sent by insurers.

Despite its size, Covered California does not lead the nation in number of terminated enrollees. More than 35,000 Florida residents are set to lose coverage in that state’s federally-facilitated Marketplace after they failed to document their legal status. However, Florida also had the most consumers at risk of losing coverage.

Iowa

Wellmark decision to opt-out of Marketplace is forcing higher premiums in individual market

The Division of Insurance announced last week that premiums for 2015 will increase in the individual market from 8.7 to 19 percent on average.

Iowa’s dominant insurer, Wellmark Blue Cross and Blue Shield, issued press statements emphasizing that only 19,000 of Wellmark’s 149,000 individual market consumers will see premiums increase by double digits, while premiums for the rest will climb by only six percent on average. The insurer pointed out that these rate hikes are far below their 18 percent average increase in 2010.



However, critics pointed out that Wellmark continues not to participate in the Affordable Care Act (ACA) health insurance Marketplace operated in Iowa by the federal government. In addition, the majority of individual market consumers under Wellmark are in ACA-deficient plans that the insurer is extending (through 2016) via the discretion granted by the Obama Administration and Division of Insurance (see Update for Week of March 3rd).

CoOpportunity Health, the non-profit cooperative created by ACA loans to compete with Wellmark, acknowledged that the sicker and more costly risk pool resulting from Wellmark's decision to opt-out of the Marketplace is forcing it to raise 2015 premiums by up to 19 percent. However, CoOpportunity Health stressed the most of their Marketplace consumers will continue to receive ACA subsidies reducing the cost of their premiums to less than \$100 per month.

Kansas

Marketplace portal updated to include participating insurers for 2015

The Insurance Department has updated the web portal for the federally-facilitated Marketplace (FFM) operated in Kansas pursuant to the Affordable Care Act (ACA). The site now lists the participating insurers for the 2015 open enrollment period starting November 15th, as well as a Tax Credit Calculator to determine 2015 eligibility for ACA premium tax credits. However, rates and plan options will not be added until the federal government releases that data in November.

Kansans in every county will now be able to choose plan options from at least two insurers, while the vast majority of counties can select from three insurers. Five health insurers will participate overall (three Blue Cross and Blue Shield carriers and two Coventry companies) and offer 82 plan options.

Louisiana

Marketplace plans hike rates by double-digits, largely blame costlier than expected patients

The Department of Insurance released data this week on insurer rate filings showing that several carriers are seeking double-digit increases in 2015 premiums for the health insurance Marketplace created by the Affordable Care Act (ACA).

The state's largest carrier, Blue Cross Blue Shield (BCBS) of Louisiana, intends to hike rates by an average of 18.3-9.7 percent for the roughly 52,650 enrollees in its Blue Saver, Blue Max, and Multi-State individual health plans. However, premiums will remain the same for subscribers in metro markets of New Orleans, Baton Rouge and Shreveport that have limited provider networks.

BCBS insisted that such significant increases were needed to cover the unexpectedly high level of health care services used by Marketplace subscribers during year one. However, critics pointed out that BCBS is receiving payments under the ACA risk corridor and reinsurance provisions to offset unanticipated claims volume from serving a disproportionate number of sicker and more costly patients.

By contrast, Humana Health Benefits Plan did agree to reduce its rate hike from the 15.5 percent it initially proposed to 9.9 percent. However, Vantage Health Plan will move forward with its planned 15.89 percent average increase.

Insurance Commissioner James Donelon unsuccessfully asked the legislature earlier this year to extend the authority granted to most other state insurance commissioners to modify or reject excessive rate hikes that do not reflect medical inflation. He noted that states with this rate review authority are seeing far more modest premium increase for their Marketplace plans (see update for Week of September 22nd).

Montana

Marketplace insurers agree to limit specialty tier coinsurance for 2015



Insurance Commissioner Monica Lindeen (D) announced on October 10th that she has reached agreement with the four participating insurers in Montana's Affordable Care Act (ACA) Marketplace to limit the use of specialty tier coinsurance for high-cost drugs.

Starting with the open enrollment period that begins on November 15th, the insurers have agreed to use fixed dollar copayments for all specialty tier drugs covered by plans at the silver level and above. Lower level bronze plans presumably can still require specialty tier coinsurance, which in federally-facilitated Marketplaces (FFMs) like Montana's forced consumers with conditions like cancer, HIV, hemophilia, multiple sclerosis, or rheumatoid arthritis to pay up to 50 percent of the total cost of their specialty medications.

Lindeen, who will head the National Association of Insurance Commissioners in 2015, pushed for the insurers to cover all drugs equally, insisting that it was discriminatory to force consumers to pay a percentage coinsurance. She noted that even though the ACA sets maximum annual out-of-pocket limits (currently at \$6,350 for an individual or \$12,700 for families), those amounts can still prevent access to critically-needed drugs if consumers have to pay the entire amount up-front.

The new policy had little effect on Marketplace premiums for 2015, which the Commissioner previously announced would increase only by an average of 1.35 percent (see Update for Weeks of August 25th and September 1st). For the second consecutive year, the Commissioner has also had the authority to reject or modify unreasonable premium increases that did not reflect medical inflation.

South Carolina

ACA Marketplace consumers to see only nominal increases in average premiums

The Department of Insurance (DOI) released final approved premiums earlier this month for individual and small group health insurance options in and out of the federally-facilitated Marketplace operated in South Carolina pursuant to the Affordable Care Act (ACA), showing only nominal average increases in both markets for the open enrollment period starting on November 15th.

For the five insurers offering individual Marketplace plans, rates will rise by an average of only 0.93 percent, with dominant carrier Blue Cross and Blue Shield of South Carolina and BlueChoice HealthPlan actually cutting premiums by more than two percent. The only double-digit increase belongs to Time Insurance Company at 21 percent.

Insurers offering individual plans outside of the Marketplace are also only increasing premiums by an average of 0.95 percent. BCBS plans are decreasing by the same amount, while only CIGNA, Freedom Life Insurance Company, and Time Insurance Company are seeking double-digit hikes.

Premiums are increasing in the small group Marketplace by an average of 3.16 percent, due largely to 2-4 percent average increases by BCBS and BlueChoice. The non-profit insurance cooperative created by ACA loans (Consumers Choice Health Insurance Company) is the only other participating insurer in the small group Marketplace and will cut rates in 2015 by an average of 2.2 percent (despite its 2.3 percent hike for individual Marketplace plans).

The nominal average increases are consistent with data released by several other states including Colorado, Maine, Massachusetts, Montana, and Washington. At least three other states (Arkansas, New Mexico, and Oregon) are expected average premiums to slightly fall.

Premium increases nationwide are averaging about six percent, according to data from preliminary rate filings in 38 states and the District of Columbia that were analyzed by PricewaterhouseCoopers (see Update for Week of September 29th). Alaska (see Update for Week of September 8th) and Louisiana (see above) are the only two states thus far have announced a "spike" in



2015 premiums, due largely to only a handful of participating insurers having to accommodate a larger than anticipated number of sicker and more costly subscribers.

Washington

ACA Marketplace streamlines renewal process for 2015

Washington Healthplanfinder officials announced last week that roughly 100,000 of the 147,000 enrollees from 2014 will be eligible to automatically renew their coverage once open enrollment begins on November 15th.

According to the Washington version of the health insurance Marketplace created pursuant to the Affordable Care Act (ACA), consumers are eligible for auto-renewal if their current qualified health plan (QHP) will be available in 2015, they provided the Marketplace with permission to check their premium tax credit eligibility for 2015, and they still qualify for coverage based on their income level, household size, residency, and citizenship status.

Healthplanfinder officials stressed that although 80 percent of the QHP options in 2014 will be offered again next year, the Marketplace will have twice as many options for consumers that wish to shop around for coverage that better suits their needs and budget, and the highest-level platinum coverage will be available for the first time (see Update for Weeks of August 25th and September 1st).