



Health Reform Update – Weeks of August 17 and 24, 2015

CONGRESS

Republicans push back against new out-of-pocket caps for family coverage

Three House committee chairs sent an August 7th letter to the Secretary for the Department of Health and Human Services insisting that the agency lacks the statutory authority to embed the annual out-of-pocket (OOP) limit that the Affordable Care Act (ACA) set for individual plans within the higher limit for family coverage.

HHS stuck the little-noticed provision into a February 27th final rule that establishes the annual OOP maximum for family coverage in Marketplace plans at the limit for self-only coverage, starting with the 2016 plan year. This substantial change was part of the agency's annual Notice of Benefit and Payment Parameters for 2016, which also required states to evaluate whether Marketplace plans employ discriminatory benefit designs, raised the tax on federally-facilitated Marketplace insurers, and lowered the threshold triggering reinsurance payments to insurers (see Update for Week of February 23rd).

The new rule relating to OOP limits means that every individual within a family plan should have a cap of \$6,850 for 2016, instead of a cap of \$13,700 for the entire family plan. HHS along with the departments of Treasury and Labor later clarified in May 26, 2015 guidance that these “embedded” limits would also apply to each individual in any non-grandfathered group health plan, including large group and self-only plans.

The guidance document provided a breakdown of how the OOP limits would now apply for 2016: For example, for a family of four (mother, father, son, and daughter) enrolled in family coverage with an OOP of \$13,700, where the mother incurs \$10,000 in cost-sharing and the other three family members incur \$3,000 each:

- The plan would pay the \$3,150 difference between the \$6,850 maximum that must now be applied to each individual and the \$10,000 cost-sharing for the mother;
- The plan would pay the \$2,150 difference between the \$13,700 cap and the family's \$15,850 in aggregate cost-sharing (\$6,850 for mother and \$3,000 for each family member).

The House letter to the HHS Secretary emphasizes that Section 1302(c)(1) of the ACA explicitly states that the OOP limit should follow those that the Internal Revenue Code sets for health savings accounts, which have separate limits for self-only and family coverage. Other commentators have pointed out that Section 1302 also applies only individual and small group coverage, and not to large group plans.

ACA tax on “Cadillac” plans could hit one-quarter of employers in 2018

The Kaiser Family Foundation released new projections this week showing that 26 percent of employers offering health benefits could be subject to the Affordable Care Act (ACA) excise tax on high-cost “Cadillac” plans when it goes into effect in 2018.

The excise tax is a major revenue-raiser under the ACA and key to the law's ability to reduce the federal budget deficit in the long-term—a key political selling point during the 2009 Congressional debate. It taxes employer-sponsored plans at 40 percent of each worker's health benefits that exceed set thresholds (initially \$10,200 for self-only coverage and \$27,500 for family coverage). The tax was



intended to keep large employers like IBM or Verizon from offering overly-generous coverage that results in over-utilization and consequently higher medical spending and premiums.

The Kaiser survey predicts that the percentage of employers with at least one health plan subject to the “Cadillac” tax could rise to as much as 30 percent in 2023 and 42 percent by 2028, unless employers adjust to the tax by eliminating coverage, increasing deductibles, narrowing provider networks, or making other downgrades in coverage.

Kaiser’s projections provide additional momentum for Congressional efforts to repeal the “Cadillac” tax, which have attracted significant bipartisan support. For example, a House bill filed by Rep. Joe Courtney (D-CT) (H.R. 2050) already has 118 Democratic cosponsors (see Update for Week of May 4th). However, some Republicans have been hesitant to back legislation repealing the tax as its intent is similar to conservative proposals to limit or end the tax-deduction for employer-provided health insurance that economists often blame for overutilization of health care.

Senate Republicans have largely focused on blocking Internal Revenue Service (IRS) guidance that would allow coverage for labor unions and “high risk” occupations to remain exempt from the “Cadillac” tax (see Update for Week of February 23rd).

Senate aides from both parties did confirm this week that a separate House-passed bill to repeal the ACA’s tax on medical device manufacturers is likely to receive a vote in that chamber before the end of the year. That measure received support from one of every five House Democrats (see Update for Weeks of June 8th and June 15th). However, even with bipartisan support, President Obama has pledged to veto a repeal of either the “Cadillac” tax or medical device tax.

FEDERAL AGENCIES

HRSA issues long-awaited guidance that narrows Section 340B drug discount program

The Health Resources and Services Administration (HRSA) released its much-anticipated “mega guidance” last week that seeks to not only create a clearer and broader definition of eligible patients under the Section 340B Drug Pricing Program but also increases program transparency and oversight regarding how covered entities are spending program savings.

The guidance has been awaiting the required Office of Management and Budget paperwork clearance since last spring (see Update for Week of May 4th) and supplements the more targeted proposed regulation that HRSA issued in June governed the calculation of ceiling prices for discounted outpatient drugs furnished to safety net provider, as well as the application civil monetary penalties for non-compliant manufacturers (see Update for Weeks of June 8th and 15th). Public comments on that rule were due on the same date last week that OMB released the guidance.

The most prominent change under the proposed guidance would double (from three to six) the number of conditions that an individual must meet to be considered a patient of a 340B-covered entity and eligible for discounted drugs. For example, an individual would not be considered a patient if his or her care was provided by another organization that “has an affiliation arrangement with the covered entity, even if the covered entity has access to the affiliated organization's records.” A patient whose drugs qualify for a discount would also be required to obtain services from a provider employed by a 340B member organization or one that can bill for services on the provider's behalf, while drugs prescribed to a patient at a non-340B entity would not qualify for discounts based on a referral from a 340B provider.

The proposed guidance also clarifies that patient drugs are considered eligible for 340B discounts if they are billed as outpatient prescriptions to an insurer. This means that a hospital that orders



prescriptions for a patient to fill at a pharmacy once discharged from the hospital would not be eligible for the 340B discount.

In addition, HRSA is proposing that no covered entity may obtain 340B pricing on a drug purchased by another covered entity at or below the 340B ceiling price.

The comment period on the latest guidance is expected to conclude on October 27th. It was issued in response to nearly unanimous dictates from a Congressional subcommittee that HRSA implement the recommendations of auditors for both the Department of Health and Human Services Office of Inspector General (OIG) and the Government Accountability Office (GAO) that blamed a lack of oversight for allowing 340B providers to reap “windfall profits” when using discounted 340B drugs to also treat Medicare or private insurance patients (see Update for Week of March 23rd).

HRSA insists they have made several efforts to increase program oversight in response to these criticisms, but are limited in the scope of what they can do, due to either court rulings or lack of Congressional authority, forcing them to often implement changes through non-binding guidance instead of formal regulations (see Update for Week of May 4th). For example, they cite last year’s court ruling invalidating HRSA rules requiring drugmakers to provide mandatory 340B discounts for orphan drugs when used for non-orphan indications—rulemaking that continues to face legal challenges brought by the Pharmaceutical Research and Manufacturers of America (see Update for Weeks of October 20th and 27th). In addition, GAO recently urged Congress to take action to eliminate incentives for 340B hospitals to prescribe Medicare beneficiaries more drugs or more expensive drugs than necessary (see Update for Weeks of June 29th and July 6th).

HRSA estimates that as of January, there were 644 drug manufacturers and 11,530 registered covered entities participating in 340B.

Treasury warns late tax filers that they risk losing ACA subsidies for 2016

The Department of Treasury sent notices last month to roughly 1.8 million households receiving premium tax credits under the Affordable Care Act (ACA) warning them that they must file their federal income tax returns for 2014 within 30 days or risk losing the tax credits for next year.

According to Treasury figures released earlier this month, the 1.8 million figure represents roughly 40 percent of all households receiving premium tax credits for 2014. About 760,000 of this group filed their 2014 returns but omitted the required Form 8962 used to track the tax credits, while another 710,000 failed to file any 2014 return. Another 360,000 requested an extension past April 15th.

Treasury is warning delinquent filers that even if they file in October, the Department may be unable to process the return in time for 2016 open enrollment that starts on November 1st. This would cause filers to lose the tax credits. To avoid such interruptions, Treasury will allow affected individuals to merely attest that they have filed a return. However, they could face criminal sanctions if they are later found to have made a false attestation once Treasury completes their review of all 2014 data in late December.

Study shows more than two million Marketplace consumers are forgoing cost-sharing subsidies

A new study released this week by the Avalere Health consulting firm concludes that more than two million consumers in Affordable Care Act (ACA) Marketplaces are failing to take advantage of cost-sharing subsidies for which they are eligible.

Congress made the cost-sharing reductions available to those earning from 100-250 percent of the federal poverty level (FPL), but only if they purchase silver tier plans. This differs from the premium



tax credits offered by the ACA, which are calculated based on the second-lowest cost silver plan but available to consumers earning 100-400 percent of FPL that purchase plans in any other metal tier.

Based upon its review of income data for consumers that enrolled in 2015 Marketplace plans, Avalere researchers determined that 8.1 million individuals qualified for the cost-sharing subsidies. However, they also found that only 5.9 million actually received the reductions.

Researchers speculated that some or most of the 2.2 million likely bought less generous bronze tier plans that had lower premiums but no cost-sharing reductions. Although bronze plans reduced their up-front costs, the study points out that those who forgo cost-sharing subsidies to purchase a bronze plan may often incur far greater out-of-pocket costs. For example, those earning 100-150 percent of FPL would be responsible for no more than six percent of their medical costs in a silver plan with cost-sharing subsidies, compared to 40 percent in a bronze plan with no reductions. (Their average annual deductible would be just \$229 compared to \$2,556 for standard silver plans.) Those earning 151-200 percent of FPL would be responsible for no more than 13 percent of costs in a subsidized silver plan and only 27 percent of costs if they earn 200-250 percent of FPL.

Study shows that most Medicare Advantage markets have little or no competition

A survey of more than 2,900 counties released this week by The Commonwealth Fund found that only Riverside County in California had a competitive marketplace for Medicare Advantage (MA) plans.

Roughly 97 percent of all counties had "highly concentrated" MA markets in 2012 with only a handful of plans from which enrollees can choose. These counties represent 77 percent of total MA enrollment and 84 percent of all Medicare enrollees nationwide.

While the study found that competition was "considerably lower" in rural areas, researchers pointed out that even among 100 counties with the most Medicare enrollees, market power for MA plans were dominated by just three insurers (Blue Cross and Blue Shield, Human, and UnitedHealth Group).

According to The Commonwealth Fund, the findings "should not be surprising" as previously analyses published in 2014 by the American Medical Association and Government Accountability Office have reached similar conclusions.

FDA draft guidance recommends unique identifiers for biosimilar products

The Food and Drug Administration (FDA) released draft guidance this week proposing to attach unique suffix identifiers on biosimilar products that share a common "core drug substance name" with their reference biologic.

The Affordable Care Act (ACA) created the new regulatory pathway for the approval of lower-cost biosimilars. The FDA approved its first biosimilar through this pathway last spring with several applications pending (see Update for Weeks of March 2nd and 9th).

Stakeholders have long-awaited the FDA's decision on whether biosimilars would require different names than reference products, with patient safety groups advocating unique names and generic drug groups opposing them. The guidance would require a suffix containing four lowercase letters without any designated meaning, regardless of whether the product was previously approved or newly-licensed. For example, "the nonproprietary name of a reference product could be replicamab-cznm, and a biosimilar to that product could be replicamab-hixf."

FDA states that this naming convention is intended to "clearly differentiate among" – and address inadvertent substitution and switching for – products determined to be non-interchangeable." It is seeking public comments on the draft guidance for 60 days.



A concurrent proposed rule suggests names for six previously-licensed products that follow this naming convention. Public comments on this rule will be accepted for 75 days.

The FDA guidance and rulemaking are separate from recent guidance from the Centers for Medicare and Medicaid Services that proposed to create single Medicare billing codes for biosimilars that reference their name brand biologics. That guidance has drawn the ire of biosimilar manufacturers and a bipartisan group of 33 members of Congress (see Update for Week of July 27th and August 3rd).

STATES

Georgia and Florida have the most narrow provider networks in the nation

A University of Pennsylvania analysis of more than 1,000 silver-tier plans sold in Affordable Care Act (ACA) Marketplaces found that more than four out of ten plans in 2014 had provider networks that included only 25 percent or less of providers in a given rating area.

The study (funded by the Robert Wood Johnson Foundation) used this 25 percent threshold to define a provider network as “narrow” and found that Georgia’s federally-facilitated Marketplace (FFM) led all states with more than 83 percent of plans relying on “narrow” networks. FFMs in Florida and Oklahoma followed closed behind 79 and 78 percent.

California was the only state among the top six states that chose to operate their own state-based Marketplace. Three-quarters of the Covered California plans surveyed used narrow networks, with FFMs in Arizona and Texas registered 73 percent.

By contrast, a dozen states including Alabama’s FFM had no health plans that narrowly limited the physicians available to consumers. The broadest networks were found in Delaware’s state-partnership Marketplace (SPM) and the FFMs for Kansas and North Dakota.

Narrow networks under Covered California have attracted the most national attention as the state is currently trying to fend off several class-action lawsuits filed by consumer groups alleging that network limitations were not properly disclosed (see Update for Week of September 29th). California has since taken several steps to ensure minimum network adequacy and accurate provider directories, and legislation remains pending this session that would standardize directories and require greater oversight (see Update for Weeks of May 18th and 25th). However, in 2014 the survey found that 38 percent of surveyed plans in Covered California used provider networks that were “x-small”, meaning they included ten percent or less of providers in an applicable rating area, while another 38 percent were considered “small”, meaning they included only 10-25 percent. Only six percent were considered “large” (40-60 percent of providers) while none were deemed “x-large” (more than 60 percent).

University of Pennsylvania researchers did recommend that states step-up efforts to ensure that consumers can determine in advance whether plans are relying upon “small” or “x-small” networks.

Alaska

Republican lawmakers file suit to block Governor’s pending expansion of Medicaid

The Legislative Council voted this week to seek a temporary injunction barring Governor Bill Walker (I) from expanding Medicaid on September 1st while a court decides whether the Governor can do so without legislative approval.



Senate Majority Leader John Coghill (R) insists that the Governor's executive action violates the Alaska Constitution. The Council appropriated \$450,000 to file the lawsuit against the Governor, with the lone Democrat on the ten-member panel being the only dissenting vote.

Governor Walker estimates that participating in the Affordable Care Act (ACA) expansion will bring Alaska roughly \$146 million in fiscal year 2016 (see Update for Week of July 13th). He called the Council's decision to file suit "disappointing" noting that Republican lawmakers could have blocked his expansion simply by passing their own alternative plan during a special session.

Arizona

Lower court upholds hospital "tax" used to fund Medicaid expansion

A Maricopa County Superior Court judge ruled this week that a simple majority was sufficient for the Arizona Legislature to expand Medicaid via an assessment on hospitals.

Former Governor Jan Brewer (R) was able to narrowly push through her plan to expand Medicaid under the Affordable Care Act (ACA) only by following through with her threat to veto all other legislation until the expansion measure was passed (see Update for Week of June 10, 2013). However, the conservative Goldwater Institute brought suit on behalf of 36 Republican lawmakers challenging that vote and insisting that the state constitution required a two-thirds supermajority to enact taxes, such as the hospital assessment that helped fund the expansion (see Update for Week of February 10, 2014).

Superior Court Judge Katherine Cooper initially ruled that the lawmakers lacking standing, concluding that losing a legislative battle does not show a concrete injury to them as individuals. However, her decision was overruled by the Arizona Supreme Court and remanded back to the Superior Court last spring (see Update for Week of March 16th).

Judge Douglas Gerlach's ruling on the merits sided once again dismissed the case, this time concluding that the hospital assessment was a "fee [that] does not qualify as a tax." As a result, a supermajority was not constitutionally required. However, Gerlach acknowledged that his decision was certain to be appealed back to the Supreme Court and in the short run has "no more impact than the outcome of a spring-training game."

Arkansas

Governor seeks to limit "private option" Medicaid expansion

Governor Asa Hutchinson (R) proposed sweeping changes this week to the state's popular alternative to the Medicaid expansion under the Affordable Care Act (ACA), as a condition of extending it past its December 2016 expiration.

Previous Governor Mike Beebe (D) made Arkansas the first state to obtain federal approval for a "private option" alternative, where the state would use ACA expansion funds to purchase private coverage in the state partnership Marketplace for those made newly-eligible for Medicaid (see Update for Week of September 23, 2013). Nearly 250,000 Arkansans have enrolled through the "private option" since its inception, resulting in one of the steepest drops in uninsured population nationwide (see Update for Week of August 10th).

However, the program has met stiff opposition in a legislature that is now fully under Republican control and the latest annual renewal was made contingent on the state making future reforms to narrow the program (see Update for Weeks of January 26th and February 2nd). A separate bill to freeze enrollment failed in the Senate by only one vote (see Update for Week of March 23rd).

Shortly after assuming office last January, Governor Hutchinson created an advisory group to make recommendations on the "private option". The Governor insists that he wants to continue the



“private option” but urged the group this week to bow to political realities and recommend changes that will satisfy Republican opponents in the legislature. These include requiring those earning 100-138 percent of the federal poverty level (FPL) to pay premiums capped at two percent of income, moving lower-income beneficiaries into less-expensive traditional Medicaid, eliminating non-emergency coverage, strengthening audit requirements, and mandating job training programs. Those who are eligible for both Medicaid and employer-sponsored insurance must also enroll in the latter, with the state covering their cost-sharing obligations.

Governor Hutchinson acknowledged that several of these changes, most notably the job training requirement, are not likely to meet federal approval based on the Obama Administration’s rejection in other states (see Update for Weeks of February 9th and 16th). However, he argued that they were necessary for the legislature to approve an additional one-year renewal when it meets in special session later this year. The Governor claimed that the reforms would save Arkansas up to \$50 million.

Governor Hutchinson concurrently announced that his Administration will resume its push to terminate coverage for roughly 47,000 Medicaid enrollees that failed to verify their income. The Department of Human Services (DHS) had demanded that nearly 600,000 enrollees Medicaid provide pay stubs or other income documentation with ten days or have their coverage terminated. However, the move sparked an outrage from consumer advocates and Democratic lawmakers, citing Federal Medicaid rules requiring at least a 30-day notice prior to any such termination. The Governor had agreed to suspend the terminations for two weeks and reinstate those enrollees that provide proof of income eligibility within 90 days of being terminated. However, he defended the 10-day window, insisting that "if somebody is not going to respond to a request from DHS for information, they're not going to respond in 10 days or 30 days."

According to DHS, two of the three insurers providing coverage through the "private option" Medicaid expansion (Ambetter Arkansas and Arkansas Blue Cross Blue Shield) have agreed to continue prescription drug coverage for 30 days after an enrollee is terminated. DHS stated that insurers will be paid retroactively if the enrollee is found to be eligible.

California

Survey confirms record drop in uninsured despite disparities in coverage

The nation’s largest state health survey released new data last week showing that the number working-age uninsured Californians fell by more than 15 percent from 2013 to 2014 due to the full implementation of the Affordable Care Act (ACA).

The results from the California Health Interview Survey of roughly 23,000 Californians found an even steeper drop among African-American adults (from 18.4 to 10.8 percent). However, uninsured rates continue to remain high among Latinos (19 percent among all age groups), reflecting a continued struggle to reach this population despite ramped-up outreach efforts to improved Latino enrollment since 2014 (see Update for Weeks of March 2nd and 9th).

Roughly four million Californians remain uninsured. The study notes undocumented immigrants continue to make up a large segment of this population, which could be reduced dramatically if S.B. 4 is enacted and expands Medi-Cal to undocumented children while allowing undocumented adults to buy-in to Covered California (see Update for Week of July 13th).

The survey also shows that more than half of all Californians continue to delay care because of cost or lack of insurance, down only slightly from 55 percent in 2013. This disparity is again much higher for Latinos (59 percent) compared to 49 percent of Caucasians and 39 percent of Asian-Americans.

Florida

Individual and Medicaid managed care plans win significant premium increases for 2016



The Office of Insurance Regulation (OIR) announced this week that it will allow insurers selling individual health plans for 2016 to increase premiums by a weighted average of 9.5 percent, while premiums for Medicaid managed care plans will increase by an average of 7.7 percent.

The individual plan increase comes out to about \$36 per month (or \$432 per year) compared to 2015 averages. However, actual premiums will vary widely depending on insurer. For example, four of the largest insurers in the federally-facilitated Marketplace (FFM) operated in Florida will all see double-digit increases led by last year's new entrant UnitedHealthcare at 16.4 percent, Humana at 16.3 percent, Preferred Medical Plan at 14 percent, and a 13.9 percent hike for Aetna. However, average premiums for the largest insurer Florida Blue stayed slightly below the statewide average and fell to as low as five percent for consumers in the Tampa Bay region. Premiums for smaller carriers like Celtic Insurance, Health Options, Florida Health Care Plan, and Molina Health Care also will all decline.

Average premiums would have increased far more dramatically in Florida were it not for a resumption of the rate review process for 2016. Governor Rick Scott (R) had signed legislation suspending all rate review for 2014 and 2015 and directing insurers to inform consumers that the Affordable Care Act (ACA) was to blame for their subsequent rate hikes (see Update for Week of May 27, 2013). Had such rate review not restarted, Aetna would have hiked premiums by nearly 21 percent while the Humana increase would have topped 26 percent.

Furthermore, the rate increases approved in Florida are far less than some of the outlier rates in other states. For example, Alaska regulators approved premium hikes of nearly 40 percent for their two Marketplace insurers, Tennessee approved a 36 percent spike for Blue Cross and Blue Shield (BCBS) and Iowa allowed a 28 percent increase for their dominant insurer Wellmark BCBS. In addition, Moda Health Plan in Oregon received a higher adjustment than proposed (exceeding 25 percent) and the non-profit cooperative that tops the Kentucky ACA Marketplace received the 25 percent increase that they insisted was needed to continue paying claims and avoid liquidation (see Update for Week of June 1st).

However, Florida's increases are still sizably larger than average rate jumps approved for dominant insurers in other states. For example, Anthem Blue Cross in Indiana will hike premiums by only a 3.8 percent average, Blue Cross and Blue Shield of Arkansas received only a 7.15 percent bump, and Anthem Blue Cross in Virginia can up their rates by an 8.6 percent average. Washington will allow only a 4.2 percent average rate hike for all of their Marketplace insurers, while individual and small group premiums in Massachusetts will increase by six percent.

The 7.7 percent average increase for Medicaid managed care plans capped contentious negotiations between the Governor and the Florida Association of Health Plans, which had sought a 12 percent average jump in response to rising costs for prescription drugs and higher numbers of physician visits (see Update for Week of July 20th). Insurers insist that the increase is not enough to offset the \$542 million that they have lost through the statewide expansion of Medicaid managed care in 2014. However, the Governor claims that any further increase would entirely wipe out the projected savings the state sought to incur from the expansion—savings that must be achieved for the federal demonstration waiver to be renewed.

State officials predict that Medicaid managed care enrollment will climb four additional percent in 2016 from the 4.2 million that are currently enrolled in capitated plans.

Georgia

Special enrollment period boost Georgia's Marketplace enrollment by ten percent

More than 55,580 Georgians have used special enrollment periods (SEPs) to sign-up for qualified health plan (QHP) coverage in the federally-facilitated Marketplace (FFM), ranking Georgia behind only Florida and Texas in SEP enrollment among FFM.



The Obama Administration created the SEP not just for those with life status changes (adding dependents, marriage, divorce, moving out of state, losing minimum essential coverage (MEC), etc.) but also for those that did not realize they were subject to the individual mandate under the Affordable Care Act until they filed their federal income tax returns for 2014. Overall, more than 940,000 consumers took advantage these SEPs to obtain FFM coverage (see Update for Week of August 10th).

Nearly half (46 percent) of Georgians enrolling in coverage through SEPs had lost the MEC that the ACA requires. Another 19 percent were deemed ineligible for Medicaid, which has not been expanded in Georgia, while 20 percent discovered they were subject to individual mandate penalties.

The 55,580 consumers using the SEP increased Georgia's FFM enrollment by ten percent.

New York

New York becomes only the second state to exercise Basic Health Plan option under ACA

The Department of Financial Services announced this month that it will make an Essential Plan available for 2016 to those earning from 133 to 200 percent of the federal poverty level (FPL) who are not otherwise eligible for Medicaid, Child Health Plus, or other government or employer-sponsored coverage.

The Essential Plan will be created under the Basic Health Program (BHP) provision of the Affordable Care Act (ACA). The federal Centers for Medicare and Medicaid Services (CMS) delayed implementation of the BHP due to concerns that it would siphon away initial enrollment from the new health insurance Marketplaces that was critically needed to ensure their financial self-viability, as the ACA required by 2015 (see Update for Weeks of January 28 and February 4, 2014).

States participating in the BHP option BHP will receive additional federal funding while CMS will save money since it will pay only 95 percent of the amount of ACA subsidies that BHP enrollees would have received had they remained in the Marketplace. Enrollees in the New York Essential Plan will also benefit, as they will receive coverage similar to the NY State of Health Marketplace, with no annual deductible, \$20 monthly premiums, and limited copayments. State officials predicted that a person earning \$20,000 a year who uses only moderate health care services will pay only about \$730 per year in premiums and cost-sharing under the Essential Plan, as compared to \$1,830 if they were enrolled in the Marketplace.

To date, New York and Minnesota are the only states that have announced plans to exercise the BHP option for 2016. Commentators noted that both states present unique circumstances that make BHPs a more attractive option than for other states. For example, New York currently uses state funds to provide health coverage to low-income legal immigrants who have resided in the United States for less than five years (making them ineligible for Medicaid). By using the BHP option, New York can now use federal instead of state funds to cover this population.

Minnesota has chosen to convert an existing state-subsidized managed care program for low-income individuals that were not eligible for Medicaid prior to the ACA expansion (such as childless adults) into a BHP program. By doing so, the state can now get the federal government to cover 95 percent of the costs for MinnesotaCare enrollees that were previously covered entirely through state funds. Enrollees will stay pay premiums of up to \$80 per month with limited copayments.

Washington

Marketplace requires individual consumers to pay premiums directly to insurers

The Washington Healthplanfinder announced last week that current enrollees in qualified health plans (QHPs) must make their monthly premium payments directly to their insurance company starting September 24th.



Consumers in the Marketplace created pursuant to the Affordable Care Act (ACA) have always had the option of paying insurers directly and nearly 20 percent have chosen to do so since the Marketplace opened in October 2013. By no longer accepting premium payments, Healthplanfinder officials are hoping to eliminate many the delays in transferring payments to carriers that have resulted from persistent glitches in the web portal. They noted that “the majority of our system issues or customer complaints have been related to invoicing and the process of transferring payments.”

Healthplanfinder officials stress that the change will not affect the calculation or application of premium tax credits and cost-sharing reductions provided under the ACA. Consumers in the small group Marketplace will also not be impacted as employers may continue to make premium payments directly to the Healthplanfinder.