



Health Reform Update – Weeks of August 31 and September 7, 2015

CONGRESS

Judge refuses to dismiss House lawsuit over ACA cost-sharing reductions

A federal judge appointed by President George W. Bush granted standing this week for House Republicans to sue the Obama Administration in an effort to block cost-sharing reductions provided by the Affordable Care Act (ACA).

House Speaker John Boehner (R-OH) filed the lawsuit last summer, insisting that the Administration lacked the authority to delay the employer mandate under the ACA and issue more than \$175 billion in cost-sharing subsidies over the next ten years through alternate funding sources without a specific appropriation from Congress (see Update for Week of July 28, 2014). U.S. District Court Judge Rosemary Collyer dismissed the employer mandate claim. However, she agreed that the “constitutional trespass” alleged in the latter claim would indeed “inflict a concrete, particular harm upon the House” and allowed the House to pursue that claim.

The case was widely expected to be dismissed by the U.S. District Court for the District of Columbia and Judge Collyer herself acknowledged that granting Congress standing into a legislative dispute was a “rare step” that carried significant “political ramifications.” She insisted that her decision would “open no floodgates” to comparable lawsuits whenever Congress disagreed with the executive branch, claiming that “it is inherently limited by the extraordinary facts of which it was born.”

White House officials indicated this week that the President was considering a rare interlocutory appeal, given the unusual nature of the decision.

Under the ACA, cost sharing subsidies are provided on a sliding scale to individuals earning from 100-250% of the federal poverty level (FPL) to help reduce out-of-pocket expenses for those purchasing silver tier plans. According to the Department of the Treasury, about 5.6 million consumers have received the subsidies as of June 30th, which totaled \$3.3 billion in 2014.

Bill to stop expansion of ACA small employer definition gains support of 40 Democrats

The House Energy and Commerce health subcommittee held a hearing this week on legislation that would let states preserve the definition of a small employer under the Affordable Care Act (ACA).

Small employers were initially defined under the ACA as those with 50 or fewer employees. However, for plan years beginning in 2016 the Affordable Care Act (ACA) expands the definition of small employers to include those with up to 100 employees. As a result, mid-sized companies with 51-100 employees must start abiding by ACA rules governing the small group market, including essential health benefits, minimum actuarial values, and premium rating restrictions. They also will start being subject to employer mandate penalties for failing to provide minimum essential coverage (MEC) to workers.

According to a March study published by the American Academy of Actuaries (AAA), being subject to these new requirements will increase premiums and adverse selection among mid-size companies with 51-100 employees. America’s Health Insurance Plans (AHIP) predicts that nearly two-thirds of the 3.4 million workers in these mid-sized companies would see premiums rise by an average of 18 percent.



As a result, H.R. 1624 (and S.1099) seeks to give states the flexibility to keep the threshold for small employer at 50 or fewer employees. The measure has drawn the support of at least 40 House Democrats including subcommittee ranking member Frank Pallone (D-NJ), even though he suggested that the legislation may be “premature”.

In addition to AAA and AHIP, H.R. 1624 is also backed by the National Association of Insurance Commissioners (NAIC), which insists that it would help mitigate premium increases by letting states ensure stability in their small group markets. However, not all insurance commissioners are in agreement, as Washington Insurance Commissioner Mike Kreidler (D) testified this week that making this change “so late in the game will be very disruptive to the market” as insurers counted on an expanded risk pool to help limit requested premium increases.

Preliminary estimates from the Congressional Budget Office (CBO) project that H.R. 1624 would save \$400 million over the next decade.

FEDERAL AGENCIES

CDC survey shows fewer Americans are forgoing medical care due to cost

A survey released last week by the Centers for Disease Control and Prevention (CDC) shows that the share of Americans foregoing medical care due to cost is at its lowest point in 16 years.

As part of its National Health Interview Survey conducted during the first three months of 2015, the agency found that only 4.4 percent of respondents reported that cost prevented them from receiving needed care during the previous year. That is the first time since 2002 that the number dropped below five percent. The only year where consumers reported a lower figure (4.3 percent) was in 1999.

CDC released data last month from the same survey showing that the nation’s uninsured rate has fallen to a record low of 9.2 percent (see Update for Week of August 10th).

IRS seeks to codify guidance requiring employer plans cover both hospital and physician services

The Internal Revenue Service (IRS) proposed new regulations last week that would require employer plans to offer both hospital and physician services in addition to maintaining at least a 60 percent actuarial value (the share of total health costs for covered benefits). Plans that fail to meet this threshold would be required to pay a fee under the employer mandate provision of the Affordable Care Act (ACA) for not providing the minimum essential coverage that the law requires.

The regulations follow-up on IRS guidance last fall, which allowed substandard plans that did not include inpatient hospitalization before November 4th to continue being offered by large employers for one year (see Update for Week of November 3rd). Plans without inpatient hospitalization are often sold at half the cost of plans that include the benefit.

However, the guidance made any employee enrolled in a plan that lacked inpatient hospitalization automatically eligible for premium and cost-sharing subsidies to purchase Marketplace coverage—even if the coverage meets the ACA affordability standard. This represented a key exception to the rule that only employees in unaffordable employer plans can be subsidy-eligible.

The IRS rule points out that while large groups plans are not required to cover the essential health benefits mandated by the ACA, those that fail to cover hospital and physician services “[do] not meet a universally accepted minimum standard of value expected from and inherent in any arrangement that can reasonably be called a health plan.” This would adversely affect sicker employees by denying



them access to a premium tax credit for individual Marketplace coverage, while at the same time averting an employer mandate fine.

The rule affirms IRS' earlier position that any employee offered a non-compliant plan will not be blocked from receiving ACA premium tax credits.

Immigration verification leads to decline in Marketplace enrollment since March

New figures on effectuated enrollment released this week by the Centers for Medicare and Medicaid Services (CMS) shows that the total number of paid consumers in Marketplace plans fell by about 238,000 during the second quarter of this year.

The CMS report attributes much of the slide to the termination of roughly 306,000 enrollees that failed to verify their immigration status. Under the Affordable Care Act (ACA), those without legal status are ineligible for Marketplace coverage.

Of the 9.9 million consumers enrolled as of June 30th, about 84 percent are receiving ACA premium tax credits to help purchase coverage. States with the highest rates of subsidy recipients are operated by the federal government, led by Mississippi at more than 95 percent, Wyoming at more than 92 percent, and North Carolina, Florida, Alabama, and Louisiana at roughly 91 percent. Conversely, states with the lowest proportion of subsidy recipients have state-based Marketplaces (SBMs), led by the District of Columbia at just over ten percent (due to federal government employees), Minnesota and Colorado at roughly 55 percent, and Hawaii at about 61 percent.

Nearly 73 percent of all enrollees belong to Marketplaces operated fully or partly by the federal government. California's SBM (with more than 1.4 million enrollees) has retaken the overall lead in enrollment from the federally-facilitated Marketplace (FFM) in Florida, while Massachusetts' rebuilt SBM (see below) saw a 26 percent jump in enrollment over the quarter. FFM's in Georgia and Mississippi led the nation with an eight percent decline in enrollment.

The vast majority of Marketplace consumers (68 percent) signed-up for silver tier plans to which the ACA premium and cost-sharing subsidies are tied. Lower-cost bronze plans were selected by 21 percent of enrollees, while only one percent signed-up for the catastrophic plans offered to young adults. The most generous but highest-cost gold and platinum plans were chosen by only seven and three percent respectively.

More than 13 million consumers have enrolled in Medicaid or CHIP since Marketplaces opened

The Centers for Medicare and Medicaid Services (CMS) released updated figures last week showing that 13.1 million consumers have been added to Medicaid or the Children's Health Insurance Program (CHIP) since the Affordable Care Act (ACA) Marketplaces opened in October 2013.

Separately, the agency released new data on Medicaid and CHIP enrollment reporting that 13.1 million more were enrolled as of June 2015 compared with a pre-Affordable Care Act (ACA) baseline. The figure is more than 292,000 higher than in May 2015, bringing total Medicaid and CHIP enrollment to nearly 72 million Americans (nearly 30 million of whom are children).

First FDA-approved biosimilar is 15 percent cheaper than brand-name biologic

The U.S. Ninth Circuit Court of Appeals denied a motion last week by Amgen to block the nation's first approved biosimilar product from entering the market.

The Food and Drug Administration (FDA) approved the biosimilar Zarxio last spring through the regulatory pathway created by the Affordable Care Act (see Update for Weeks of April 6th and 13th).



Amgen brought suit challenging the approval, claiming that Sandoz had not shared required manufacturing information for the competitor to its biologic cancer drug Neupogen. It is appealing a lower court's dismissal of that suit and sought an injunction blocking Zarxio until the appeal is heard.

Biosimilars were expected to dramatically lower the cost of biologic drugs and the initial wholesale price for Zarxio is roughly 15 percent lower than for Neupogen. This discount is similar that witnessed in European markets where Zarxio has already been competing with Neupogen but below the 35 percent price drop that consultants like RAND Corporation ultimately project over ten years.

The Medicare Payment Advisory Commission (MedPAC) decided this week to back the Centers for Medicare and Medicaid Services (CMS) proposal to create single billing codes for biosimilars that reference the same brand biologics, despite the bipartisan opposition from a group of at least 33 members of Congress (see Update for Weeks of July 27th and August 3rd). MedPAC commissioners dismissed claims from the biosimilar industry that the proposal would treat biosimilars the same as generic drugs and lower reimbursement to the point where it would effectively limit competition. Instead, the commissioners concluded that the proposal would lower the price of both biosimilars as well as their more costly brand-name biologic counterparts, and that biosimilar companies were simply seeking "price protections" via "separate billing codes [that] will artificially keep prices higher than they otherwise would be under a single billing code."

STATES

Large Marketplace insurers continue to seek higher rates, narrower plan options for 2016

Highmark Health became the latest of several large insurers last week to announce plans to scale back offerings in Affordable Care Act (ACA) Marketplaces for 2016 following sizeable financial losses blamed on a sicker pool of subscribers than anticipated.

According to *The Wall Street Journal*, Highmark lost \$318 million on individual Marketplace plans during the first three months of 2015, forcing it to more severely limit its network of providers and plan offerings for the upcoming open enrollment period. The insurer notes that the losses account for reinsurance payments under the ACA that are not sufficiently reflecting the higher than projected mix of subscribers—payments that end after 2016. (Highmark currently participates in the Marketplaces for Delaware, Pennsylvania, and West Virginia.)

Highmark's move follows the announcement by Blue Cross and Blue Shield (BCBS) of Texas last month that it would no longer offer preferred provider organization (PPO) options for individual consumers and is withdrawing about 367,000 such plans after incurring more than \$400 million in "unsustainable" losses for 2014. North Carolina BCBS is seeking a 35 percent rate hike and already decided to no longer offer its broadest-network plan in three of the state's most populous cities following \$123 million in first-year losses (see Update for Weeks of July 27th and August 3rd), while New Mexico BCBS withdrew entirely from that state's Marketplace after regulators rejected its proposed rate hike of more than 51 percent (to cover \$19.2 million in losses).

The losses have already forced regulators in Maryland to approve a more than 30 percent premium increase for CareFirst BCBS (see below) while the Oregon Insurance Commissioner felt compelled to give large insurers in her state higher increases than they requested in order to "stabilize" the market (see Update for Weeks of June 8th and 15th).

Alaska

Courts allow Medicaid expansion to proceed....for now



A Superior Court judge has rejected to a request by Republican lawmakers to issue a temporary injunction against the Medicaid expansion plan by Governor Bill Walker (I), allowing it to start as scheduled on September 1st.

The Governor relied on rarely-used executive authority to circumvent the legislature while it was out of session and accepted Medicaid expansion funds under the Affordable Care Act (ACA) to cover all Alaskans earning up to 138 percent of the federal poverty level (see Update for Week of July 13th). Republican lawmakers had previously stripped his expansion plan out of the state budget and tried to insert a provision prohibiting him from accepting the ACA funds before the Legislative Affairs agency ruled that line item unconstitutional (see Update for Weeks of March 2nd and 9th).

The Legislative Council filed suit insisting that only the legislature has the authority to determine Medicaid eligibility (see Update for Weeks of August 17th and 24th). However, Judge Frank Pfiffner ruled last week that the plaintiffs failed to show “irreparable harm” from letting the expansion commence while the case was decided nor did they provide evidence that they would ultimately prevail on their claim that the governor overstepped his authority.

The Alaska Supreme Court also rejected an appeal last week of Judge Pfiffner’s decision by the Legislative Council. Despite the loss, the Council insists that it will continue to pursue its underlying challenge to the Medicaid expansion.

Arkansas

CMS orders state officials to cease wrongful terminations of Medicaid benefits

The Department of Human Services has suspended its effort to terminate Medicaid coverage for up to 55,000 enrollees that failed to verify their income within ten days of the state’s request to do so.

Governor Asa Hutchinson (R) had previously suspended the terminations for two weeks after consumer advocates complained that the ten-day window violated Federal Medicaid rules requiring at least a 30-day notice prior to any such termination (see Update for Weeks of August 17th and 24th). He briefly resumed the termination on August 18th, defending the use of the ten-day window. However, he suspended the terminations last week for a second time after the federal Centers for Medicare and Medicaid Services (CMS) directed state officials to adhere to the 30-day window in federal rules.

The additional time will not be granted retroactively to those 17,000 whose coverage was already terminated. However, DHS did send notices informing them that they still have 90 days from the termination to appeal and will be reinstated to Medicaid if they provide proper income documentation.

California

Senate drops effort to allow undocumented adults to purchase Marketplace coverage

The Assembly Health Committee passed an amended version of legislation this week that would expand Medi-Cal coverage for the children under age 19 who lack legal status in the United States.

The amendments principally removed a provision that would require state officials to seek a federal waiver allowing undocumented adults to purchase coverage through Covered California with their own funds. Acknowledging that the provision would delay the bill and impede its passage this session, bill sponsor Ricardo Lara (D) agreed to remove and reinsert it in separate legislation (S.B. 10) that the legislature is set to consider next year.

S.B. 4 is now similar to the earlier budget proposal from Governor Jerry Brown (D) that would expand Medi-Cal to about 170,000 undocumented children starting May 2016 (see Update for Weeks of June 8th and 15th). The expansion is projected to cost \$40 million for the remainder of fiscal year 2015 and \$132 million in subsequent fiscal years.



Legislature passes several consumer protection bills, including limits on out-of-pocket drug costs

The legislature this week passed several bills to protect health consumers before the September 11th close of the legislative session, setting the stage for Governor Jerry Brown (D) to either sign or veto them by the October 11th deadline. These include:

A.B. 159: This measure unanimously passed both chambers and would authorize manufacturers of investigational drugs not yet approved by the Food and Drug Administration (FDA) to make those drugs available to patients with medical conditions that are immediately life-threatening.

A.B. 339: This measure would require non-grandfathered health plans offering outpatient prescription drug coverage on or after January 1, 2017 to limit cost-sharing to no more than \$250 for a 30-day supply of an individual prescription (or \$500 for bronze tier plans as defined by the Affordable Care Act), consistent with caps recently adopted for Covered California (see Update for Weeks of May 18th and 25th).

The caps would sunset on January 1, 2020 without additional legislation and apply for federally-defined high deductible health plans only after the annual deductible has been satisfied. For non-grandfathered individual and small group products the outpatient drug deductible would not exceed more than twice these limits.

The bill also would prohibit formularies from “discouraging the enrollment of individuals with health conditions and [not reducing] the generosity of the benefit” for a particular condition in a manner that is “not based on a clinical indication or reasonable medical management practices.”

Other provisions would require these plans cover non-formulary drugs determined to be medically necessary and apply the same cost-sharing as for a formulary drug. Starting in 2017, plans must maintain a pharmacy and therapeutics committee responsible for developing, maintaining, and overseeing any drug formulary list.

A.B. 1305: This measure would ensure that individual patients are subject only to the annual out-of-pocket maximum set by the ACA for individuals (currently \$6,600), even if they are in a family plan (see Update for Weeks of June 8th and 15th). Senate amendments delayed implementation for the large group market until January 1, 2017.

Covered California has already adopted a standard benefit design for 2016 that includes similar provisions and about 98 percent of health plans in California also apply this standard. The bill would mostly impact high-deductible health plans that have aggregated deductibles or out-of-pocket maximums for family members.

S.B. 137: This measure requires updated, standardized, and accurate health plan provider network directories as of July 1, 2016. It is in response to several class-action lawsuits filed against Covered California insurers last year after consumers unexpectedly incurred out-of-network costs due to provider directories that were frequently unavailable, incomplete, or erroneous (see Update for Week of September 29, 2014).

S.B. 248: This measure would prohibit health plans in the large group market from offering “junk insurance” by that they provide a minimum actuarial value of at least 60 percent. The Affordable Care Act (ACA) currently requires that individual and small group plans meet at least this 60 percent threshold, which is equivalent to the lowest-tier bronze plan created by the ACA.

The Assembly did refuse this week to concur with Senate amendments for A.B. 533. That measure sought to protect consumers who “do the right thing by seeking care in an in-network



facility, only to later receive a surprise bill from an out-of-network provider that had been called in to provide service.” The amendments that prevented passage included a provision creating a “mandatory and binding” independent dispute resolution process that would resolve claim disputes between insurers and non-contracted health professionals.

Legislature passes bill to delay shift of vulnerable children into Medicaid managed care

The Assembly passed legislation this week that would delay the transition of roughly 195,000 children with severe and rare disorders into capitated managed care plans under the Medi-Cal program.

A.B. 187 passed both chambers with unanimous approval and is expected to be signed by Governor Jerry Brown (D). At issue are Medi-Cal children with specific conditions that are served under the California Children’s Services program, whose carve-out from Medicaid managed care ends in January. However, A.B. 187 would extend the carve-out and postpone any transition until January 2017.

Colorado

Medicaid expansion drives almost all of record drop in uninsured

A new survey from the Colorado Health Institute revealed last week that the record drop in Colorado’s rate of uninsured is due largely due the state’s expansion of Medicaid pursuant to the Affordable Care Act (ACA).

The results showed that nearly one of every three of Colorado’s 5.3 million residents is now covered by the Medicaid program after 450,000 were added subsequent to the ACA expansion that started in January 2014, shattering the prediction of Governor John Hickenlooper (D) that the expansion would add 160,000 residents to the Medicaid rolls. As a result, Colorado now has the nation’s fourth fastest-growing Medicaid program behind only Kentucky, Oregon, and Nevada.

The Colorado Health Access Survey found that Colorado’s uninsured rate has plummeted from a recent high of 15.8 percent four years ago to 6.7 percent this year. However, the survey also identified several concerning trends. For example, the rate of those underinsured (i.e. paying more than ten percent of income on out-of-pocket medical costs) actually rose to 16.4 percent. Additionally, the Connect for Health Colorado Marketplace accounts for only 42 percent of the entire individual market, meaning that the number of consumers enrolling in individual coverage has stayed roughly the same since before the ACA (at roughly 409,000).

Colorado has also seen a decline in the percentage of consumers with employer-sponsored coverage (from 58 to 51 percent), though researchers note that trend pre-dates the ACA. The loss in employer-sponsored coverage has occurred among small businesses (despite the creation of the ACA small group Marketplace) as large employers in Colorado have actually expanded coverage post-ACA.

Connecticut

State regulators limit individual market premium hikes to 3.5 percent average

Insurance Department officials released final premiums this week for individual health coverage offered in 2016, showing an expected weighted average increase of 3.5 percent.

Most of the approved increases were downgraded by state regulators from the rates proposed by insurers. For example, United Healthcare sought an 11.4 percent average increase for individual Marketplace plans but received only a 5.5 percent bump. For non-Marketplace plans, their average increase was reduced from 32.9 percent to 21.7 percent. The proposed rate hike from dominant carrier Anthem Blue Cross was cut nearly in half from 4.7 to 2.4 percent, while Golden Rule received only a 1.1 percent increase after seeking to hike rates by 18.5 percent.



Of the four insurers participating in the individual Marketplace, the HealthyCT non-profit cooperative created with Affordable Care Act (ACA) loans received the highest average increase at 7.2 percent. However, the Insurance Department more than doubled HealthyCT's proposed hike of only 3.43 percent, as the cooperative surprisingly enrolled nearly 24,000 consumers on and off the Marketplace last year, leading to concerns about its ability to pay claims as ACA funding becomes exhausted. Several other ACA cooperatives have already needed to be liquidated after ACA loans were exhausted (see Louisiana below), leading states like Oregon to likewise boost artificially low premium proposals in an effort to ensure their financial viability (see Update for Weeks of June 8th and 15th).

Louisiana

Insurance Commissioner takes over failed ACA health insurance cooperative

Insurance Commissioner Jim Donelon (R) announced last week that his office is assuming control of the Louisiana Health Cooperative, which is the non-profit consumer owned and operated plan (COOP) created with \$56 million in Affordable Care Act (ACA) loans.

The Commissioner secured a court order allowing him to take full possession and control over the COOP based upon state law authorizing him to do so whenever an insurer "is found to be in such condition that its further transaction of business would be hazardous to its policyholders, its creditors or the public." Louisiana Health Cooperative will stop selling policies immediately and will discontinue all plans as of January 2016.

Commissioner Donelon stressed that the company's existing 17,000 consumers will not be impacted in the short term and "should continue to pay premiums in the same manner, schedule doctor appointments and be assured that their policies will be honored."

Louisiana Health Cooperative is only one of several COOPs that have been liquidated nationwide (see Update for Weeks of February 9th and 16th). However, in other cases, enrollment far surpassed projections, leaving the COOPs unable to cover claims costs. By contrast, Louisiana Health Cooperative struggled with enrollment, signing-up less than half of the 28,000 it initially projected for 2014 and experiencing a 23 percent decline in 2015—the worst performance of any of the nation's 23 COOPs. The result was a \$20 million deficit just by the end of 2014 as well as 106 consumer complaints being filed with the Department of Insurance—the highest per consumer rate of complaints among Louisiana's five major insurers.

Recent audits by the Inspector General for the federal Department of Health and Human Services have shown that Maine's COOP is the only one of the 23 COOPs that is not currently losing money.

Maryland

Individual Marketplace to see 12 percent average rate hike, despite rate cut for small groups

The Maryland Insurance Administration (MIA) released final approved premiums last week for both individual and small group plans offered in the Maryland Health Benefit Exchange for 2016.

State regulators stressed that final rates were reduced by roughly \$66.4 million from the amounts that insurers initially proposed. However, individual plans in the Exchange will see an overall average increase of 11.9 percent, with the three carriers under the umbrella of dominant insurer CareFirst Blue Cross and Blue Shield receiving whopping increases of 26.7 to 30.4 percent to cover reported losses of more than \$100 million. The other five carriers received either single-digit increases or lowered their premiums by an average of up to 3.2 percent.

Average premiums in the small group Exchange will actually fall by 1.8 percent as four carriers (including the three belonging to CareFirst) are lowering premiums by up to a 16.6 percent average. None



of the other seven insurers in the small group Exchange are receiving more than the 8.5 percent average hike belonging to Aetna.

MIA noted that only 8.2 percent of all Marylanders are covered under either individual or small group Exchange.

Massachusetts

Health spending spikes by nearly five percent due to Medicaid expansion, Marketplace flaws

A new report from the Massachusetts Center for Health Information and Analysis found that health care expenditures doubled from 2013 to 2014 due to the state's expansion of Medicaid under the Affordable Care Act (ACA) and pervasive technical problems with the Massachusetts Health Connector.

The 4.8 percent increase in overall spending not exceed the rate of medical inflation but also the 3.6 percent annual benchmark set by Massachusetts' landmark cost containment law enacted three years ago (see Update for Weeks of July 23 and 30, 2012). The \$54 billion in total spending represents an average of more than \$8,000 per resident compared to \$7,641 in 2013.

The director for MassHealth, the state Medicaid program, insists that the spending spike was only temporary. The report found that Medicaid spending shot up 19 percent in 2014 as 325,000 Connector applicants were moved into temporary coverage until website flaws could be resolved (on top of 379,000 added due to the eligibility expansion)(see Update for Weeks of April 28 and May 5, 2014). She notes that Medicaid enrollment actually declined by 205,000 over the first three months of 2015 after Massachusetts launched a rebuilt web portal for the ACA Marketplace (see Update for Week of August 4, 2014) and projects only a six percent spending increase for 2015.

However, the report also pointed to a 13 percent increase in prescription drug costs, which caused Senate President Stan Rosenberg (D) to call for a bulk drug purchasing program similar to ones that he claims have brought down drug costs in other states.

The report found that although private insurance premiums rose more quickly in 2014 than in 2013, the 2.6 percent bump remains modest when compared to other states. It credits cost-shifting by employers for keeping premiums in line, noting that employees were increasingly moving into plans in 2014 that imposed higher deductibles and tiered copayments.

Marketplace eliminates one-third of plan options for 2016

The board for the Massachusetts Health Connector approved several changes this week for 2016 that are intended to improve the consumer shopping experience, including expanding the number of call centers and walk-in centers, enabling consumers to make account changes online, and reducing the number of plan offerings to limit confusion.

As a result, the Connector will offer one-third fewer plan options (down from 126 to 84) by eliminating the least popular plans. Officials estimate that roughly ten percent of Connector consumers were enrolled in plans that will no longer be available next year and will automatically be transferred to other plans unless they opt-out.

Connector premiums for 2016 will increase by an average of 2.2 to 7.8 percent for the 48,000 consumers that are not eligible for premium subsidies under the Affordable Care Act. However, subsidy recipients will actually see premiums fall by an average of 2.1 percent.

Michigan

Governor seeks federal approval to expand premiums for Medicaid expansion population



The Michigan Department of Health and Human Services formally asked the Obama Administration last week to raise premiums for the nearly 600,000 low-income residents covered under the state's private sector alternative to the Medicaid expansion under the Affordable Care Act (ACA).

Governor Rick Snyder (R) and state officials have been negotiating with the Centers for Medicare and Medicaid Services (CMS) since last spring on an extension of their existing Healthy Michigan waiver, which will end April 30th without a renewal. The initial waiver allowed Michigan to charge recipients 3-5 percent of their income for coverage, depending on their earnings (see Update for December 16, 2013-January 3, 2014). A resident with an income of \$12,000 per year would contribute three percent or \$240 annually.

CMS has until the end of 2015 to decide whether to approve Michigan's new terms, which would increase the maximum premium to seven percent of income. The Medicaid expansion bill approved by the Republican-controlled legislature required the expansion population choose after 48 months between the seven percent "contribution" to remain on Healthy Michigan or purchase coverage on the federally-facilitated Marketplace operated in Michigan (see Update for Week of August 26, 2013).

CMS is currently not expected to approve either provision, as the seven percent premium exceeds the five percent cap it has approved in other states and the ACA does not allow individuals already covered by Medicaid to purchase Marketplace coverage.

State officials acknowledge that "we certainly pushed the boundaries with our first waiver" and the more severe requirements sought in their waiver request may "need to [be] work[ed] through.....to see what kind of middle ground there is."

Ohio

Court rules that state must include spouse when determining QMB eligibility

In a decision that could impact all state Medicaid programs, a three-judge panel on the U.S. 6th Circuit Court of Appeals held last week that Ohio must count a spouse as a member of the family when determining whether Medicaid will pay the Medicare cost-sharing for a dual-eligible applicant.

The cost-sharing assistance is provided for those defined as a Qualified Medicare Beneficiary (QMB). The decision directs state officials not to exclude a Medicaid enrollee's spouse when it comes to income calculations for QMBs simply because the federal law doesn't define the word "family." The panel remanded the case back to the lower court where the three individual plaintiffs will ask to certify a class of 80,000-100,000 affected enrollees. All three plaintiffs have spouses that are not eligible for Medicare and have no income.

The 6th Circuit is the first to address Ohio's interpretation of federal law that insisted resident spouses were not part of the "family" for income calculations—an interpretation shared by 16 other states. Ohio officials had claimed during the case that the only time they would count the resident spouse was if both were eligible for Medicare.

Pennsylvania

State officials complete transition to traditional Medicaid expansion

The Department of Human Services (DHS) announced last week that it has completed the transfer of more than one million adult Medicaid enrollees into a new single benefit package that is part of the Medicaid expansion instituted by new Governor Tom Wolf (D).

Former Governor Tom Corbett (R) had made Pennsylvania one of six states to receive a federal waiver to cover those made newly-Medicaid eligible by the Affordable Care Act (ACA) expansion under private Medicaid managed care plans instead of traditional Medicaid (see Update for Week of December



1st). However, his Healthy PA “private coverage option” was beset with enrollment delays and technical impediments it opened last December (see Update for Week of January 12th) and Governor Wolf decided to convert it into a traditional ACA expansion shortly after assuming office (see Update for Week of February 9th).

DHS officials stopped accepting Healthy PA applicants in April and instead of the three tiers of benefits offered under Healthy PA they started enrolling new applicants directly into a single Medicaid HealthChoices Program (see Update for Weeks of March 2nd and 9th). DHS stated that they are on course to meet their projection of 605,000 newly-eligible Medicaid enrollees at some point in 2016 and have not received reports of physicians or hospitals being “overwhelmed” by the added numbers.