



## Health Reform Update – Week of January 4, 2016

### CONGRESS

#### ***President vetoes broad ACA repeal bill, but agrees to delay two ACA taxes***

For the first time in 62 tries, Republican lawmakers delivered to President Obama this week a measure that would repeal major provisions of the Affordable Care Act (ACA).

The broad repeal bill (H.R. 3762) was largely symbolic as President Obama promptly followed through on his promised veto and both chambers lack enough votes for an override. However, conservative groups like Heritage Action for America insisted that the measure would “provide momentum to help make the full repeal of Obamacare a reality in 2017” under a Republican president.

The House initiated H.R. 3762, which was expanded by the Senate before being passed with only a bare majority through a process called budget reconciliation and returned to the House (see Update for Week of November 30<sup>th</sup>). Senate Democrats used the same reconciliation procedure to enact several key provisions of the ACA in 2009.

As he did last fall (see Update for Weeks of October 5<sup>th</sup> and 12<sup>th</sup>), Collin Peterson (D-MN) was the lone House Democrat to vote in favor of the bill this week, due to his support for a separate provision defunding Planned Parenthood. Reps. Robert Dold (R-IL), Richard Hanna (R-NY), and John Katko (R-NY) were the only Republicans to break ranks and oppose the bill.

By relying on budget reconciliation to circumvent a Senate filibuster (that requires 60 votes to break), Republicans could only target specific ACA provisions that impact the federal deficit. As a result, H.R. 3762 would have only eliminated the penalties used to enforce the controversial individual and employer mandates under the ACA, while leaving the mandates themselves intact.

However, the bill effectively would have “gutted” the ACA by stopping all premium and cost-sharing subsidies under the ACA starting in 2017, which are critical to ensure the affordability of plans for mid-to-lower income Americans. In addition, it sought to block any further reinsurance and risk corridor payments that compensate insurers for exceptional claims and roll back the provisions allowing states to be reimbursed for nearly all of their expenses for expanding Medicaid.

Several key revenue provisions of the ACA would also have been eliminated, including the current tax on medical device manufacturers and excise tax on high-cost “Cadillac” plans. However, Republicans likely achieved these goals through an omnibus spending bill that President Obama signed last month, which suspended the device tax for 2016 and 2017 while delaying the “Cadillac” tax for two years past its 2018 effective date. Neither is expected to be resumed.

Democratic lawmakers criticized Republican leaders for not putting forth their promised replacement for the ACA after passing H.R. 3762. House Speaker Paul Ryan (R-WI) insisted that such an alternative plan had been formulated and would be released in the near future.

#### ***Senate Democrats push CMS to contain prescription drug costs***

Five Senate Democrats continued their push last month to get the Centers for Medicare and Medicaid Services to be forthcoming about agency initiatives to curb prescription drug costs.



Senators Mark Warner (D-VA), Bill Nelson (D-FL), Jeanne Shaheen (D-NH), Heidi Heitkamp (D-ND), and Tim Kaine (D-VA) signed a December 17<sup>th</sup> letter to the acting CMS Administrator asking for CMS to detail how it will maximize existing authority to ensure that consumers in the individual market have access to costly medications. In particular, they are encouraging the agency to bring greater transparency to drug pricing for consumers, as well as identify alternative payment mechanisms that can help lower Medicare and Medicaid spending on prescription drugs.

Senators Susan Collins (R-ME) and Claire McCaskill (D-MO), who lead the Senate Special Committee on Aging, also announced that the panel has commenced a bipartisan Senate investigation into pharmaceutical drug pricing.

In response to the heightened legislative scrutiny from both sides of the aisle (see Update for Week of November 30<sup>th</sup>), CMS did unveil an online Medicare Drug Spending Dashboard last month that is intended to promote greater drug pricing transparency for consumers. It includes 2014 pricing data for 80 drugs covered under either Medicare Parts B and D and shows pricing trends over the previous five years. CMS states that it specifically selected drugs that recently experienced severe price increases, had high levels of per patient spending, or were among the top 15 in total spending for either program.

The dashboard data reveals that Medicare spending on prescription drugs grew by nearly 17 percent in 2014, up from 9.5 percent the year prior. The 80 drugs included in the database accounted for about \$55 billion in Medicare prescription drug spending for 2015 (\$3 billion of which went to the Sovaldi drug approved for hepatitis C). This \$55 billion equaled about 40 percent of the \$140 billion that Medicare spent on prescription drugs in 2014. They also account for 71 percent of all Part B drug spending, compared to only 33 percent for Part D.

Drug spending is likely to climb further in 2016 after the Food and Drug Administration (FDA) approved 45 first-of-a-kind medications in 2015, breaking the 2014 total of 41 that had been the highest figure since 1996.

## FEDERAL AGENCIES

### ***Federal Marketplace enrollment for 2016 exceeds prior year total***

More than 8.6 million consumers have enrolled in coverage through the federally-facilitated Marketplace (FFM) currently operating in 38 states, according to the most recent figures released this week by the Department of Health and Human Services (HHS).

The pace of enrollment for 2016 has thus far exceeded the 6.5 million sign-ups at the same point in the 2015 open enrollment period. More than 70 percent of 2016 enrollees are returning customers (and 60 percent changed plans). However, despite an early spike in the enrollment of young adults (age 18-34), that critical demographic now represents only 26 percent of FFM sign-ups, or roughly the same percentage as at the same point in 2015. CMS had hoped to improve upon this ratio in order ensure insurer stability through broader risk pools and help minimize the number of insurers leaving Marketplaces due to a shortfall in federal reinsurance payments (see Update for Week of December 7<sup>th</sup>).

Florida, which led all states in 2015 enrollment, continues to far outpace other FFMs with nearly 1.6 million enrollees or 98 percent of last year's total. Only Texas is close at nearly 1.1 million while North Carolina lags far behind at just below 554,000.

Enrollment predictably surged just before the December 15<sup>th</sup> deadline for January 1<sup>st</sup> coverage, with more than six million consumers signing-up the extension that HHS granted until December 17<sup>th</sup> (due to heavy website traffic). Open enrollment will continue through January 31<sup>st</sup>.



An additional 2.7 million consumers have enrolled in the 13 state-based Marketplaces (SBMs) created pursuant to the Affordable Care Act. SBMs like Washington reported similar enrollment surges in December that put it on a pace that exceed 2015 open enrollment by 48 percent. Over 71 percent of sign-ups in Washington's SBM were returning customers, also comparable to FFM figures.

### ***CMS provides more detail on 2017 network adequacy standards***

The Centers for Medicare and Medicaid Services (CMS) used its annual letter to federally-facilitated Marketplace insurers to further detail the new network adequacy standards that the agency left undefined in an earlier proposed rule.

The Notice of Benefit and Payment Parameters for 2017 proposed to let states retain control of their own network adequacy determinations so long as they met maximum travel distance and appointment time standards set by CMS. They also created an exceptions process states can use if they believe certain counties are too rural for the standards to apply.

CMS has deliberately left its standards rather vague in response to numerous complaints from state officials that the agency was "encroaching on their regulatory rights" and ignoring the model network access and adequacy law finalized last month by the National Association of Insurance Commissioners (NAIC). As a result, CMS will use a "reasonable access" standard to make sure that FFM issuers are building networks large and diverse enough to ensure access to services "without unreasonable delay."

The agency intends to supplement the NAIC model act and "allow states flexibility to apply a standard that takes into consideration their specific needs." States can also indicate to CMS prior to the plan certification process that starts April 11<sup>th</sup> whether they intend to use a time and distance standard or a provider-to-enrollee ratio. Regardless of the standard chosen, all states must send to CMS data on the availability of physicians, providers, and pharmacies.

CMS will provide a file for issuers to confirm whether meet time and distance standards. These range from requiring that at least 90 percent of enrollees have access to at least one primary care provider within ten minutes or five miles in a large metropolitan county to at least one inpatient psychiatric facility within 155 minutes or 140 miles in "counties with extreme access considerations." The file will also define the specialties and facilities and will be available as part of the certification process.

The letter states that CMS will elaborate on these requirements as part of the certification process for qualified health plans (QHP). It did not include details on what a standard provider-to-member ratio might be or how states should calculate them.

Once the new requirements are in place, CMS will label each QHP on [www.Healthcare.gov](http://www.Healthcare.gov) so that FFM consumers can account for the narrowness of provider networks when selecting plans. These labels or provider participation rate (PPR) will measure "network breadth" by comparing each network's size to that of other QHPs in the same county.

QHPs would be labeled as having either standard, basic, or broad networks. Any plan with a network that falls within one standard deviation above the mean PPR would be deemed "standard." If the network's PPR is more than one standard deviation below the mean, it would be "basic" and those that are more than one standard deviation above the mean would be "broad."

CMS intends to analyze QHP provider network data for 2017 using the same methodology as 2016, when the agency found about 68 percent of plans had "standard" network size. The agency is proposing to "focus on hospitals, adult primary care, and pediatric primary care" based on priorities set by consumer feedback. These classifications may change in future years.



In cases where a provider leaves a network, the agency expects issuers notified impacted subscribers at least 30 days beforehand.

Comments on the letter are due by January 17<sup>th</sup> while a final version is expected in early 2016.

### ***OIG says automated system should resolve CMS failure to verify ACA tax credit eligibility***

The Office of the Inspector General (OIG) for the Department of Health and Human Services (HHS) issued an additional report this week confirming that the Centers for Medicare and Medicaid Services (CMS) still lacks any effective process for ensuring that tax credit payments made to insurers under the Affordable Care Act (ACA) were accurate.

The findings showed that CMS could not verify that payments to insurers were only for eligible consumers that paid their plan premiums. Previous OIG reports have shown that both federally-facilitated and state-based Marketplaces lacked adequate controls to ensure that premium tax credits and cost-sharing subsidies were benefiting only consumers that were eligible (see Update for Week of September 14<sup>th</sup> and 21<sup>st</sup>). In addition, audits by the Government Accountability Office (GAO) showed that tax credits were going to fictitious consumers in the federal Marketplace (see Update for Week of July 13<sup>th</sup>).

According to OIG, CMS currently relies on each insurer to provide aggregated information to determine the total amount in tax credits that the insurer should receive. As result, the OIG concludes that "there is a risk that funds were authorized for payment" in incorrect amounts, even though CMS emphasized that OIG cited no specific example of an overpayment to an insurer.

However, the report further concludes that a fully-automated system due to be implemented early this year is likely to alleviate these potential problems.

According to the Obama Administration, insurers received nearly \$11 billion in tax credit payments in fiscal 2014. For 2015, roughly 85 percent of enrollees received premium tax credits that average \$270 per month.

## **STATES**

### ***Study shows double-digit hikes in average premiums and deductibles for silver and bronze plans***

A new analysis of Marketplace premiums for all 50 states (and the District of Columbia) released last month by the Robert Wood Johnson Foundation shows that consumers purchasing the most popular silver-level plans for 2016 will be forced to pay an average of 11 percent more in premiums.

For a 27 year old male, researchers found that the average silver-plan will now approach \$300 per month while deductibles will climb eight percent. The increases are even more dramatic for the more generous gold-level plans, whose average premiums will jump nearly 14 percent.

The findings reveal a much higher average increase than the 7.5 percent cited by the Obama Administration for benchmark silver plans in the federally-facilitated Marketplace. Benchmark plans are those upon which the premium tax credits and cost-sharing subsidies under the ACA are based.

It also showed huge spikes in deductibles for some states, as the average for family coverage in Washington soared 76 percent to \$3,500 per year, while Mississippi and South Carolina jumped by 42 and 37 percent respectively. Alaskans will experience the steepest hikes in average silver-plan premiums (35 percent for a 27 year old male), while Minnesota, Montana, and Hawaii consumers will all be hit with average increases of more than 30 percent. For North Carolinians, both Marketplace premiums and deductibles for silver plans will climb by an average of 20 percent.



Researchers found an even steeper average hike for the less generous bronze plans (an average of 13 percent), while average deductibles will also increase by the same amount. Furthermore, Marketplace consumers in 29 states will have fewer gold tier plans from which to choose, with five states losing more than half of their gold coverage.

#### Arkansas

##### ***Governor submits request to put new limits on popular Medicaid expansion alternative***

Governor Asa Hutchinson (R) formally submitted Arkansas' request last week to modify the federal waiver allowing it to enroll more than 225,000 consumers that are newly-eligible for Medicaid into private coverage through the state partnership Marketplace (SPM).

Arkansas was the first state to receive federal approval to use matching funds provided under the Affordable Care Act (ACA) to purchase Marketplace coverage for those made newly-eligible for Medicaid under the expansion (see Update for Week of September 25, 2013). Six other states have since received federal approval for similar models (see Update for Week of November 30<sup>th</sup>).

The Department of Human Services (DHS) submitted a public notice of intent last month to solicit public comment on its proposed modifications, which include charging premiums capped at two percent of income on those earning 100-138 percent of the federal poverty level (FPL), moving lower-income beneficiaries into less-expensive traditional Medicaid, eliminating non-emergency coverage, and mandating job training programs (see Update for Week of December 7<sup>th</sup>). However, no comments were received, either in writing or at the hearing.

Arkansas had until December 31<sup>st</sup> to ask the Obama Administration to change the waiver, which expires at the end of 2016. However, the detailed proposal will not be submitted until it is approved by the full legislature during a special session. The Governor's Health Reform Legislative Task Force voted in favor of the proposal last month, causing Medicaid expansion opponent Senator Terry Rice (R) to promptly resign from the panel.

According to the Kaiser Family Foundation, the popularity of the Private Option has allowed Arkansas to reduce its uninsured rate by more than any other state since 2013.

#### Iowa

##### ***Inadequate provider networks force CMS to delay Medicaid managed care transition***

The federal Centers for Medicare and Medicaid Services (CMS) informed Iowa's Medicaid director last month that the state is not prepared to transition its Medicaid program to managed care and will not receive approval to do so until at least March 1<sup>st</sup>.

Governor Terry Branstad (R) had planned to move Medicaid enrollees into four out-of-state health plans starting January 1<sup>st</sup> (Amerigroup Iowa, AmeriHealth Caritas Iowa, UnitedHealthcare Plan of the River Valley and WellCare of Iowa.) However, consumer and provider groups including the Iowa Hospital Association insisted that the move was "rushed" and petitioned both CMS and the Polk County District Court to delay implementation.

In its letter to the state Medicaid director, CMS agreed with these groups that "significant gaps" in operational readiness "would risk serious disruptions in care for Iowa Medicaid beneficiaries" if the transition proceeded on January 1<sup>st</sup>. This included inadequate provider networks that "lack key providers" within a reasonable distance and an over-reliance on out-of-network providers.



Kansas

***Committee seeks to deny HCV drugs to all Medicaid enrollees that engage in risky behavior***

The joint KanCare Oversight Committee approved a controversial set of draft recommendations last week that would control prescription drug costs primarily by withholding costly new Hepatitis C drugs from patients that fail to follow treatment protocols or consume non-prescription drugs or alcohol.

Medicaid programs in at least 34 states have already taken steps to ration the availability of the latest HCV “cures” (see Update for Week of July 28<sup>th</sup> 2014) that can cost \$84,000-94,000 for a 12-week course of treatment and have driven the greatest spike in drug costs over the past decade (see Update for Weeks of March 2<sup>nd</sup> and 9<sup>th</sup>). The director of the National Association of Medicaid Directors insists that states have little choice given that the cost covering these drugs for every Medicaid enrollees with HCV can be more than 300 percent of the total pharmacy budget in several states. KanCare itself has already spent \$3.1 million on HCV medication during just the first four months of fiscal year 2016.

However, most states have sought to limit coverage to patients that are most critically in need, such as those that already have liver damage or are also infected with HIV. If the draft recommendations are approved this session by the legislature, Kansas would be the first to actually punish HCV enrollees what Senator Jim Denning (R) termed as “knowingly engag[ing] in behaviors that undermine the effectiveness of their medications.”

The two Democrats on the panel objected to the recommendations, insisting that they amounted to a “death sentence” by depriving a critically-ill enrollee of life-saving treatments. Senator Mary Pilcher-Cook (R) acknowledged that restricting access could be fatal but stated that enrollees willfully decided to risk their lives by engaging in risky behavior and should be held accountable.

The panel also approved draft recommendations that would allow the three KanCare insurers covering nearly all Medicaid enrollees in managed care plans to implement step therapy protocols. These would allow the insurers to restrict the ability of physicians to prescribe costly drugs until cheaper alternatives have been tried and proven ineffective. Similar proposals have been introduced in legislatures nationwide.

Kentucky

***New Governor backs off pledge to terminate Medicaid expansion***

Governor Matt Bevin (R) announced this week that he will release a proposal by mid-2016 to seek a federal waiver to create a private-sector alternative to Kentucky’s traditional Medicaid expansion under the Affordable Care Act (ACA), in which more than 400,000 Kentuckians are enrolled.

Seven states have received a Section 1115 demonstration waiver allowing it to use matching funds provided by the Affordable Care Act (ACA) to purchase private coverage for the newly-eligible Medicaid population (see Update for Week of November 30<sup>th</sup>). The Governor’s expansion alternative is expected to closely follow the model federally-approved for Indiana, which relies upon state-created health savings accounts. However, unlike the Section 1115 waivers pursued by other states, Bevin’s approach would seek a Section 1332 waiver that the ACA created to allow states to experiment with their own comprehensive reforms as long coverage is expanded to an equivalent number of state residents at the same cost or lower cost.

Kentucky would be among the first states to pursue a Section 1332 waiver, which can be submitted starting January 1, 2017. Vermont had planned to do so before its transition to a single-payer system was scuttled last year and Colorado voters will decide the fall whether to pursue a similar single-payer plan via the Section 1332 process.



Governor Bevin said he remained opposed to the traditional expansion enacted by his Democratic predecessor Steve Beshear. Even though his decision to pursue a Medicaid expansion alternative softens his campaign pledge to eliminate Beshear's expansion entirely, Governor Bevin insisted that he remains committed to converting the state-based Marketplace also created by Beshear into a federally-facilitated Marketplace controlled by the Obama Administration (see Update for Week of November 30<sup>th</sup>).

According to the Kaiser Family Foundation, polls show that 72 percent of Kentuckians (including 54 percent of Republicans) want the Governor to keep the expansion as it is, while a slim majority opposes changes to the Marketplace. Due largely to these two reforms, Kentucky experienced the second-largest reduction in its uninsured rate since 2013 (second only to Arkansas).

#### Louisiana

##### ***New Governor sets July 1<sup>st</sup> date for Medicaid expansion***

Governor-elect John Bel Edwards (D) announced this week that he plans to expand Medicaid under the Affordable Care Act (ACA) on July 1<sup>st</sup>.

The incoming Governor has pledged to issue an executive order "within 24 hours" of assuming office next week that would accept ACA funds to expand Medicaid to everyone earning up to 138 percent of the federal poverty level and circumvent legislative opposition (see Update for Week of November 30<sup>th</sup>). However, his new Secretary for the Department of Health and Hospitals acknowledged that such an ambitious timeline would be difficult to achieve, as the agency may not be able to hire all of the estimated 250 new staff needed to accommodate an influx of 300,000 new Medicaid enrollees, nor ensure that they all have received Medicaid cares by July 1<sup>st</sup>.

It also remains unclear what legal or procedural roadblocks Republican lawmakers may be able to put in the path of the Governor's expansion, as the additional agency cost for salaries, training, and equipment can exceed \$2 million and the state must assume ten percent of the expansion costs in 2020 and subsequent years.

#### Michigan

##### ***CMS approves amendments to Medicaid expansion waiver***

The Centers for Medicare and Medicaid Services (CMS) approved Michigan's request to amend its Healthy Michigan Section 1115 demonstration waiver, through which the state provides coverage under Medicaid managed care plans to more than 594,000 adults made Medicaid-eligible by the Affordable Care Act (ACA).

Michigan is one of seven states with a federally-approved alternative to the traditional ACA expansion (see Update for Week of November 30<sup>th</sup>). However, Public Act 107 passed by the legislature requires the program to terminate on April 30<sup>th</sup> if the state so did not seek additional changes to by last September 1<sup>st</sup>.

The amendments approved by CMS apply to the upper-end of the Medicaid expansion population earning from 100-138 percent of the federal poverty level (FPL). These enrollees will now be provided with a choice of receiving coverage through Medicaid managed care or a qualified health plan in the federally-facilitated Marketplace operated in Michigan. Premiums for this group will increase from two percent of income to 3.5 percent—the highest-level that CMS has approved for any state—while the cost-sharing cap will go beyond the five percent of income permitted by federal Medicaid law to seven percent of income.

#### New York

##### ***New law makes pregnancy a qualifying event for special Marketplace enrollment***



Governor Andrew Cuomo signed legislation last month make New York the first state to allow pregnant women to enroll in health insurance coverage outside of the annual open enrollment period.

The bill (S. 5972/A. 6780B) defines pregnancy as a “qualifying life event” that triggers a special enrollment period, similar to the 60-day window created after consumers get married, divorced, add dependents, gain citizenship, move to another state, or lose their eligibility for minimum essential coverage. The Affordable Care Act (ACA) failed to include pregnancy under the list of qualifying events, which forced pregnant women to incur up to \$20,000 in out-of-pocket costs for prenatal and maternity care according to the comptroller for New York City (see Update for Week of June 22, 2015).

## Ohio

### ***Federal judge dismisses Attorney General's challenge to ACA tax***

A federal judge dismissed a lawsuit this week challenging the Affordable Care Act (ACA) tax on state and local government health plans.

The lawsuit filed by Attorney General and former U.S. Senator Mike DeWine (R) was the first to challenge the tax on self-insured group health plans and was joined by four public universities in Ohio. The plaintiffs argued that there was no precedent for such a “broad-based tax” and that the Obama Administration was unconstitutionally diverting some of the \$6.25 million that the tax collected from Ohio government entities in 2014 into the U.S. Department of Treasury’s general fund instead of the ACA’s temporary reinsurance program, as Congress intended the revenues from the tax to be used to help compensate health insurers that incurred exceptional claims costs due to the ACA’s guaranteed issue mandate.

However, Judge Algenon Marbley of the U.S. District Court for the Southern District of Ohio concluded that the assessment is constitutional because it regulates the government entities in their capacities as employers. Judge Marbley was appointed to the court by President Clinton.

### ***Secretary of State temporarily blocks ballot measure targeting prescription drug prices***

Secretary of State Jon Husted (R) ordered county boards this week to investigate whether the AIDS Healthcare Foundation received a sufficient number of legitimate signatures to put a statewide ballot referendum before the legislature that would limit prescription drug costs.

According to the foundation, the *Drug Price Relief Act* received 116,105 signatures, requiring the legislature to either act on the bill within the four months or allow its enactment to be decided by the voters on their November ballots. The Secretary of State had initially certified the “initiated state ballot issue” and forwarded it to the General Assembly, since it had well above the required 91,677 signatures.

The measure would require state and state-funded agencies to pay no more for prescription drugs than the lowest price paid by the U.S. Department of Veterans Affairs. It specifically aims to lower the cost of drugs for especially costly conditions like HIV/AIDS and hepatitis C.

Despite his initial certification, Secretary Husted directed boards of election this week to review the signatures by January 29<sup>th</sup> and ensure their validity, in response to information he received on December 30<sup>th</sup> from an in-state law firm representing the Pharmaceutical Research and Manufacturers of America (PhRMA). The Secretary said that crossed-out signatures of people who signed 5,598 “part-petitions” warranted the review, which will temporarily prevent the ballot measure from moving forward.

The AIDS Healthcare Foundation promptly filed a petition with the Ohio Supreme Court to block the Secretary’s action, which it called “completely bogus and politically motivated”. It claimed that





PhRMA has spent \$38 million opposing a comparable ballot referendum in California that is also backed by the foundation and certified just last week.

## Texas

### ***Decline in uninsured rate lags far behind nation***

Nearly 1.1 million Texans have enrolled in Marketplace coverage through December, according to the most recent figures released by the U.S. Department of Health and Human Services (HHS). The figure is the second-highest among the 38 states participating in the federally-facilitated Marketplace (FFM) for 2016. However, new studies from the Milliman consulting firm and Rice University found that despite the 20 percent increase in the number of Texans with health insurance, the state's uninsured rate is falling by only half the rate of the 41 percent drop in uninsured nationwide over the last two years.

For over a decade, Texas has led the nation in the number of uninsured, with nearly a quarter of its population lacking health insurance coverage. Combined with its refusal to expand Medicaid under the Affordable Care Act (ACA), its coverage expansions have thus lagged far behind other states. According to Gallup, its uninsured rate fell by only 15 percent from 2013-2015 and it still leads the nation with more than 20 percent of its population uninsured.

In addition, FFM consumers in many parts of Texas are being provided with fewer coverage options. For example, Blue Cross and Blue Shield of Texas has stopped offering all PPO plans for 2016 FFM consumers, as have CIGNA and Humana. This has resulted in Houston-area consumers from Harris County—the fourth largest in the country—having no PPO plans despite competition among seven different Marketplace carriers.

Roughly two thirds of the 14 Marketplace carriers in Texas reported losing money in 2015 and claim that switching to an all-HMO model helps them to better predict and control costs.

Texas is one of five states that defaults to HHS for rate review. However, rates for the benchmark silver plans (upon which the ACA premium and tax credit subsidies are based) increased by only 5.1 percent for 2016. Five carriers will actually see average premiums decrease, while the rest received average rate hikes of five to 34 percent. Consumers with several of the state's largest carriers will see substantial rate hikes including Blue Cross and Blue Shield's HMO plan (18.8 percent), Humana's HMO plan (23 percent), and Scott and White Health Plan (32.4 percent).