



## Health Reform Update – Week of September 12, 2016

### CONGRESS

#### ***Ways and Means clears bill that would exempt failed CO-OP consumers from tax penalties***

The House Ways and Means Committee advanced a measure last week on a voice vote that would create a narrow exemption from the individual mandate under the Affordable Care Act (ACA) for consumers of failed non-profit insurance cooperatives.

Only six of the 23 Consumer Owned and Operated Plans (CO-OP) are continuing to operate following substantial Marketplace losses that caused most to collapse (see below). The losses were largely attributable to the CO-OPs use of low premiums to attract far more consumers than they could handle, as well as a shortfall in ACA reinsurance that failed to promptly compensate them from an unexpected influx of high-cost subscribers (see Update for Week of November 30<sup>th</sup>) and a flawed ACA risk corridors formula that forced them to pay up to 28 percent of their revenues to dominant carriers (see Update for Week of August 15<sup>th</sup>)

According to the Joint Committee on Taxation (JCT), roughly 725,000 individuals had purchased coverage from one of the failed CO-OPs. The legislation (H.R. 954) sponsored by Rep. Adrian Smith (R-NE) would specifically exempt these consumers that lost coverage mid-year from the ACA mandate that they purchase minimum essential coverage they can afford (or pay a tax penalty of \$695 or 2.5 percent of income for 2016).

Democrats in the minority on the insisted that the exemption was unnecessary as those who lost coverage mid-year were automatically eligible for a special enrollment period to purchase other coverage (see below) or would likely qualify for the hardship exemption already created by the ACA. JCT staff had no information on how many of these consumers have already purchased other coverage or paid the tax penalty. Rep. Jim McDermott (D-WA) accused Republicans are using H.R. 954 to “spread misinformation about the co-op program...without so much as a hearing.”

#### ***Senate Republicans seek additional exemptions to individual mandate under ACA***

A group of Republican Senators led by John McCain (R-AZ) introduced legislation this week that would nullify the individual mandate under the Affordable Care Act (ACA) for Marketplace consumers residing in counties with less than two coverage options.

Senator McCain was spurred to introduce the bill (S.3296) by last month’s withdrawal of Aetna from the Arizona Marketplace (see Update for Week of August 15<sup>th</sup>), a move that appeared to leave Pinal County with zero participating insurers for 2017 until Blue Cross and Blue Shield agreed this week to temporarily serve the county (see below). Senators Ron Johnson (R-WI), Tom Cotton (R-AR), Ben Sasse (R-NE), Jeff Flake (R-AZ), and John Barrasso (R-WY) immediately cosponsored the bill.

According to an analysis by the Kaiser Family Foundation, the bill would exempt those consumers residing in an estimated 31 percent of counties that will have just one Marketplace insurer for 2017—a dramatic increase from only seven percent in 2016. Roughly 62 percent of all Marketplace enrollees will still be able to choose from three or more insurers, a drop from 85 percent this year.

A related measure (S.3297) was also introduced by Senator Cotton that exempts consumers from the individual mandate if they reside in a state where the average premium for self-only or family



coverage for the second-lowest cost silver plan is more than ten percent greater than the prior calendar year.

### ***Senate Democrats open probe into Aetna departure from most ACA Marketplaces***

Senate Democrats led by Elizabeth Warren (D-MA) are demanding answers from Aetna regarding its recent decision to abandon most Affordable Care Act (ACA) Marketplaces after the Department of Justice (DOJ) blocked its proposed merger with Humana.

As recently as last May, Aetna had announced plans to expand its Marketplace presence for 2017. However in July, it sent a letter to DOJ officials stating that a refusal to allow its merger to move forward would result in its decision to exit the Marketplaces. Aetna subsequently announced that it would leave 11 of the 15 Marketplaces in which it participated for 2016 (see Update for Week of August 15<sup>th</sup>).

In a terse letter to the Aetna chief executive officer, the Senate letter asks the insurer to disclose the “exact costs Aetna will incur now that the Justice Department has challenged the merger” including financial data substantiating Aetna’s claim that they have lost \$300 million on Marketplace business. The letter also seeks the specific date that Aetna decided to make their Marketplace presence contingent upon merger approval.

The Senators also want to know how many Marketplace consumers have contacted Aetna over its decision to abandon the Marketplaces and details on the insurer’s plans to re-enter the Marketplaces in subsequent years.

Joining the letter were Senators Bernie Sanders (I-VT), a former Democratic presidential candidate, Bill Nelson (D-FL), a former insurance commissioner, Edward Markey (D-MA), and Sherrod Brown (D-OH). The two Senators from Connecticut, a state traditionally favorable to insurers, chose not to sign on, with Senator Chris Murphy (D-CT) accusing his colleagues of trying to make Aetna a “scapegoat” during an election year, insisting that Aetna officials were not acting in “bad faith”.

## **FEDERAL AGENCIES**

### ***Uninsured rate falls below nine percent for first time***

The latest survey data from the Centers for Disease Control and Prevention found that the nation’s uninsured rate fell to a new record low of 8.6 percent during the first quarter of 2016.

CDC surveys had previously shown a drop in the uninsured rate to 9.1 percent (see Update for Week of May 16<sup>th</sup>), compared to 14.4 percent in 2013, just before full implementation of the Affordable Care Act (ACA). As with that survey, the largest reduction in the uninsured is continuing to occur among young adults age 19-25 (which fell 2.6 percentage points in 2015). However, the uninsured rate for 26 year olds continues to remain the highest across all ages, which is likely attributable to the fact that the ACA only allows young adults to remain on their parents’ group coverage until that age.

Separate data concurrently released by the Bureau of the Census showed that median household income rose 5.2 percent last year, the first gain since the economic recession from 2007-2009. The increased income for consumers helped bring down the national poverty rate by 1.2 percent, representing the largest single year drop since 1999. Both factors are expected to significantly improve the nation’s uninsured rate in future quarters.



## ***New Marketplace standards revise risk adjustment but ignores plan discrimination***

The Centers for Medicare and Medicaid Services (CMS) released their proposed Notice of Benefit and Payment Parameters (NBPP) for 2018 last week, three months earlier than usual.

The premature publication was likely an effort not only to finalize the standards before a new Administration arrives in January but to limit further insurer defections from Affordable Care Act (ACA) Marketplaces following the loss of major players like UnitedHealth Group, Humana, and Aetna (see Update for Week of August 15<sup>th</sup>). This is because the NBPP makes several efforts to respond to insurer complaints about the Marketplace risk pools (which they claim are sicker and more costly than projected) without placing upon them additional restrictions such as requiring that they accept third-party premium assistance from non-profits.

The most prominent change alters how CMS will calculate risk stabilization payments under the ACA. These payments were meant to stabilize Marketplace premiums by making insurers with healthier and less costly risk pools compensate those that took on sicker and more costly subscribers. However, they have resulted in bizarre situations where small non-profit competitors like Evergreen Health in Maryland are forced to pay the state's dominant carrier CareFirst Blue Cross and Blue Shield more than \$22 million or 26 percent of its total premium revenue—payments that Evergreen and three other CO-OPs are currently suing CMS in an effort to block (see Update for Week of August 15<sup>th</sup>). The risk corridor formula is largely blamed for forcing all but six of the 23 CO-OPs created with ACA loans to fail (see below).

As a result, the new rules will alter the formula for calculating risk corridor payments starting in 2018. The changes specifically will account for subscribers that enroll outside of open enrollment periods (which insurers claim are usually sicker). They will also include prescription drug data for high-cost conditions like hepatitis C, HIV/AIDS, end-stage renal disease and diabetes.

Through the rule, CMS is effectively planning to continue the risk stabilization program in place of the ACA reinsurance program that ends after 2016. The reinsurance program was the one that compensated insurers for exceptionally high-cost claims (not just those that are above average).

CMS will start defining high-cost enrollees as those with costs in excess of \$2 million per year. The costs for high cost enrollees would be pooled across all states and across the individual and small group markets. Insurers who incur claims in excess of \$2 million would be reinsured through the risk adjustment program for 60 percent of the excess cost (and would continue to bear 40 percent of the cost). This modification of the formula would only affect about 0.1 percent of premiums in either market but help prevent the dramatic losses that were incurred by certain insurers.

Other changes are intended to encourage younger (and theoretically healthier) individuals to enroll. These include adding age-band ratings for children in order to prevent a large jump in premiums (of up to 57 percent) when they turn 21. Whereas the ACA allows a single rating band from birth through age 20, the NBPP would set one rating band up to age 14, after which premiums would tick up by small percentages until they hit 0.97 percent of premium at age 20 (compared to 0,635 now).

CMS is also catering to insurers by boosting the annual out-of-pocket limit to \$7,350 (or \$14,700 for non-single coverage) and upping the affordability threshold for employer plans to 8.05 percent of subscriber income. Unlike 2017, they also will start allowing insurers to impose separate pharmacy and medical deductibles for both silver and gold tier plans.

The agency is also giving insurers more flexibility in how they can design the lowest-cost bronze-tier plans, but requiring them to at least offer both silver and gold-tier plans in the Marketplace.



The NBPP keeps most standardized options that are in place for 2017, including a single provider tier, fixed deductible, fixed cost-sharing limit, and fixed copayment or coinsurance for essential health benefits. CMS also will not increase the user fee for the federally-facilitated Marketplace (FFM) from 3.5 percent of premiums. However, the user fee under the six state-based Marketplaces (SBMs) that are defaulting to the federal web portal (Arkansas, Hawaii, Idaho, Kentucky, Nevada, and Oregon) would increase in 2018 from 1.5 percent to three percent.

In order to boost participation in FFMs, CMS is also considering removing the requirement that insurers in the individual FFM also offer coverage in the small group FFM.

Commenters including Patient Services Inc. criticized the NBPP for not addressing third-party premium assistance for non-profits. CMS had stated in its proposed NBPP for 2017 that it would consider requiring Marketplace plans to accept such assistance, with certain limits (like making it payer of last resort behind Medicare and Medicaid). However, it decided not to act in the final 2017 NBPP standards and its complete omission for 2018 suggests that the agency is no longer considering such a requirement because of the Marketplace defections. Aetna, in particular, partly blamed non-profit assistance for its recent decision to leave 11 of its 15 Marketplaces (see Update for Week of August 15<sup>th</sup>).

Although the NBPP was the expected vehicle for CMS to make any change regarding non-profit premium assistance, the agency certainly could still do so in separate rulemaking at any time. A Congressional bill that would force it do so (H.R. 3742) currently has 112 bipartisan cosponsors.

### ***CMS will divert all ACA risk corridor funding in 2015 to cover 2014 shortfall***

The Centers for Medicare and Medicaid Services (CMS) announced this week that is diverting funds due insurers in 2015 under the Affordable Care Act (ACA) risk corridor program to cover the shortfall that remains in 2014 funding.

The temporary risk corridors program was meant to stabilize health insurance premiums by using funds collected from all insurers to compensate those with extraordinary claims costs. However, insurers have so far received only 12.6 percent of the \$2.87 billion they were due for 2014, after extraordinary claims costs exceeded the amounts contributed (see Update for Week of November 30<sup>th</sup>). The shortfall has been directly responsible for the liquidation of 16 of the 23 Consumer Owned and Operated Plans (CO-OPs) created with ACA start-up loans, as well as indirectly led to the decision by several major insurers to leave most or all of their ACA Marketplaces for 2017 (see Update for Week of August 15<sup>th</sup>).

At least four CO-OPs are suing CMS to recover their 2014 costs (see Update for Week of August 15<sup>th</sup>). CMS acknowledged the lawsuits in their announcement and stated that they are willing to start negotiating a resolution to those claims.

This week's decision by CMS means that insurers will receive no risk corridors payments for 2015 until 2016 collections are completed and disbursed. The Secretary for the Department of Health and Human Services (HHS) suggested this week that the agency will lobby Congress for full funding if CMS is unable to cover all risk corridors payments for the final year of the program in 2016. However, the Republican-controlled Congress has blocked CMS from fully-funding the program since 2014, with leading Republicans insisting that the payments amounted to an "insurer bailout" (see Update for Weeks of January 5, 2015).

### ***CMS to test verification system for special enrollment periods***

The Centers for Medicare and Medicaid Services (CMS) announced last week that it is launching a pilot program in 2017 that will test ways to verify enrollee eligibility for special enrollment periods (SEPs) that allow consumers with qualifying life events (such as adding dependents, losing minimum essential



coverage, permanent relocation, etc.) to purchase coverage outside of the annual open enrollment period.

CMS has already taken action to eliminate several SEPs and require consumers to provide proof of eligibility in response to insurer complaints that the SEPs were being [ab]used by healthier consumers who were simply waiting for an illness or injury before deciding whether to purchase Marketplace coverage (see Update for Week of February 8<sup>th</sup>). The agency announced this week that those steps have already reduced SEP enrollment by 15 percent.

The pilot would focus on creating an actual “pre-enrollment verification system” that would automatically ensure that only those eligible for SEPs are able to enroll, instead of trying to validate eligibility after consumers have signed-up.

The move was largely praised by insurers but met with caution by consumer groups concerned that overly burdensome requirements would depress the enrollment of otherwise eligible individuals. They cited a recent Urban Institute study revealing that only five percent of the 33.5 million individuals who become SEP-eligible each year actually enrolled in 2015 (see Update for Week of July 18<sup>th</sup>). Urban Institute researchers had warned that creating additional documentation barriers would further depress enrollment of eligible consumers and encouraged CMS to instead using an electronic verification system that only requires documentation when eligibility is unable to be determined through existing computer databases. For example, since more than 94 percent of SEP enrollees apply due to loss of minimum essential coverage, eligibility can be verified for the vast majority of cases simply by data-matching with the applicant’s prior insurer.

## HEALTH CARE COSTS

### *Employer plan deductibles rose dramatically in 2016*

Health insurance deductibles among employer-sponsored plans jumped by 12 percent in 2016, according to the latest analysis released this week by the Kaiser Family Foundation.

Researchers attribute the dramatic increases to the trend of consumers being increasingly willing to shift to plans with higher out-of-pocket costs but lower monthly premiums.

The study found that employer-sponsored premiums remained roughly the same from 2015 to 2016 for individual coverage and increased by only three percent for family coverage (roughly the same increase as in 2015). However, average annual deductibles rose 12 percent from \$159 to \$1,478.

Researchers did note that there was wide variability among deductibles charged by large firms with more than 200 workers (\$1,238 on average) and the \$2,069 average for small firms.

## STATES

### Arizona

#### ***Blue Cross and Blue Shield reluctantly enters county left with no Marketplace insurers***

Blue Cross and Blue Shield (BCBS) of Arizona agreed this week not to follow through with plans to eliminate Marketplace coverage for Pinal County after 2016, leaving residents of that county with at least one Marketplace option for next year.

Aetna’s decision last month to exit the federally-facilitated Marketplace in Arizona (along with ten other states) had meant that no Marketplace carriers would serve Pinal County. However, at the urging of the Department of Insurance and the federal Centers for Medicare and Medicaid Services, the state’s



largest carrier agreed to continue serving the area, though will not remain beyond one year unless regulators “find a way to stabilize the market and put long-term fixes in place.”

BCBS is one of only four carriers that will remain in the Marketplace, which was considered among the most robust in the nation as recently as 2015 when 11 carriers participated. However, three carriers dropped out in 2016 and five more are departing next year (including Aetna, Humana, and United Healthcare).

Furthermore, the four carriers (BCBS, Health Net, CIGNA, and Centene) will compete only in the southernmost county of Pima (which includes metro Tucson). CIGNA and Centene will be the lone carriers offering Marketplace coverage for Arizona’s largest county of Maricopa (which includes metro Phoenix), while BCBS will focus only on 13 largely rural counties.

The lack of any statewide competition is likely to dramatically increase Marketplace premiums for 2017. The three remaining carriers have proposed to increase premiums by an average of 49.3 percent, including the 51.2 percent hike sought by BCBS. However, Arizona had only a \$324 average Marketplace premium in 2016, far below the \$396 average among the 38 states that used the federal portal (only Utah had a lower average pre-subsidy premium).

Just over 203,000 Arizonans enrolled in Marketplace coverage during the 2016 open enrollment period.

#### California

#### ***Legislation protecting consumers from surprise medical bills heads to Governor***

Governor Jerry Brown (D) is expected to shortly sign legislation that would protect consumers from “surprise” out-of-pocket costs that consumers incur from out-of-network care furnished at in-network facilities.

A.B. 72 would require that consumers pay only in-network rates in such situations, similar to legislation enacted earlier this year in Florida and Connecticut (see Update for Week of April 18<sup>th</sup>). The measure is a compromise from a similar bill last session (A.B. 533) that failed by only three votes. Unlike last year’s bill, A.B. 72 was backed by both consumer groups like Health Access California and insurers like Anthem Blue Cross and Blue Shield. It passed nearly unanimously on the last day of the session.

Medical specialty associations largely continue to oppose the bill, including the American College of Surgeons, the California Orthopedic Association and the American Society of Plastic Surgeons.

A Consumers Union survey in 2015 found nearly one in four privately insured Californians who were hospitalized or had surgery were charged an out-of-network rate at an in-network facility.

Governor Brown has already signed one consumer protection measure (S.B. 923 to prevent mid-year increases in insurer cost-sharing), while another (S.B. 908) that awaits his signature would require insurers to notify subscribers of rate hikes that the insurance commissioner deems “unreasonable” (see Update for Week of August 22<sup>nd</sup>).

The Governor signed two consumer protection measures last year that capped prescription drug cost-sharing (A.B. 339) and mandated accurate provider directories (S.B. 137) (see Update for Weeks of October 5<sup>th</sup> and 12<sup>th</sup>).



Connecticut

***Marketplace avoids having only one insurer for 2017***

The largest insurer in the Affordable Care Act (ACA) Marketplace for Connecticut changed course this week and dropped its appeal of final approved premiums for 2017.

ConnectiCare Insurance Company had insisted last week that the 17.4 percent average rate hike approved by the Department of Insurance was not adequate for it to continue serving their 48,000 Access Health CT subscribers (or half of all of the Marketplace's consumers). They not only filed a Superior Court challenging the decision, but also an administrative appeal with the Department itself.

After Access Health CT officials agreed to "temporarily" extend this week's deadline for insurer's to decide whether to participate next year, ConnectiCare ultimately decided that based on consumer input their participation was too vital for the survival of the Marketplace and agreed to remain despite not receiving the 27.1 percent hike they had demanded. ConnectiCare had initially sought only a 14.3 percent average premium increase, before revising their request to 17.4 percent on August 4<sup>th</sup>. However, they since claimed that newly-revealed data shows they will lose \$20 million on Marketplace business without dramatically higher premiums.

ConnectiCare was under pressure from both state and federal regulators to remain in the Marketplace, which had already lost two of its four carriers from 2016 when UnitedHealth Group and the HealthyCT non-profit cooperative departed (see Update for Week of April 18<sup>th</sup>). It will be joined by Anthem Blue Cross, which received a 22.4 percent average rate hike from the Department.

Overall, regulators approved a 25 percent average rate increase for the entire individual market (and a 13 percent average rate increase for small groups). The increases are dramatically higher than the 3.5 percent approved last year for the individual market (and 2.9 percent for small groups) due largely to the end of the ACA's temporary reinsurance and risk corridor program (see above).

Illinois

***Medicaid relaxes coverage requirements for costly Hepatitis C drugs***

Illinois became the latest state this week to stop rationing coverage of drugs treating the Hepatitis C virus (HCV) to only those most severely ill.

The state's Medicaid program became the first to restrict coverage of HCV drugs in 2014 only to those most in need following Food and Drug Administration (FDA) approval of Sovaldi, a "cure" that cost more than \$84,000 for a course of treatment (see Update for Week of July 28, 2014). Oregon and 32 other states followed with coverage criteria that were in many cases even more restrictive (see Update for Weeks of January 11<sup>th</sup> and 18<sup>th</sup>).

The Illinois Medicaid policy had limited coverage of HCV drugs only to those with stage 4 liver scarring. The new policy will now allow coverage as well for stage 3 liver scarring.

At least four states have already broadened coverage to all HCV enrollees following a determination by the Centers for Medicare and Medicaid Services and a federal court in Washington that rationing of hepatitis C drug coverage violates anti-discrimination provisions of federal Medicaid law (see Update for Week of June 20<sup>th</sup>).

Kansas

***Most uninsured Kansans are eligible but not enrolled in Marketplace or Medicaid coverage***

The Kansas Health Institute issued an annual report last week concluding that half of the nearly 302,000 uninsured Kansans are eligible but not enrolled in coverage through the health insurance



Marketplace created by the Affordable Care Act (ACA), while nearly 17 percent are already eligible for Medicaid or the Children's Health Insurance Program (CHIP). The latter figure would jump to 31.9 percent if Kansas decides to participate in the Medicaid expansion under the ACA.

Overall, researchers found that the percentage of uninsured Kansans fell from 12.3 to 10.5 percent just during the first year of full ACA implementation.

#### Maryland

#### ***Marketplace consumers to face 25 percent average rate hike***

Consumers in the state-based Marketplace that Maryland created pursuant to the Affordable Care Act (ACA) will be forced to pay an average of 25.2 percent more for coverage under final premiums approved last week by state regulators, unless they switch to lower-priced plans.

The highest increases went to the state's dominant carrier, CareFirst Blue Cross and Blue Shield, which insisted that they were needed to cover more than \$620 million in Marketplace losses resulting from a sicker and more costly risk pool than anticipated. CareFirst's Marketplace consumers will see rates for PPO plans increase by 31.4 percent on average (down from the 36.6 percent it requested), with another 23.7 percent average increase for HMO coverage (down from the 27.8 percent it sought). (CareFirst controls 68 percent of the individual market in Maryland).

The three other carriers competing in the Marketplace also received more than a 20 percent average increase, including the Evergreen Health Cooperative, which is one of only seven of the nation's surviving Consumer Owned and Operated Plans (CO-OPs) that were created with ACA loans. Evergreen sought only an 8.8 percent average rate hike, but regulators increased their request to 20.3 percent (still the smallest increase granted to any Marketplace carrier).

Evergreen is currently suing the federal government to block its required \$24 million payment to CareFirst under the ACA's risk corridors program, representing more than 25 percent of its 2015 premium revenue (see Update for Week of June 20<sup>th</sup>). State regulators insisted that a 20.3 percent average rate hike was needed to ensure that Evergreen could cover this cost if its lawsuit failed.

Urban Institute researchers noted that Marketplace premiums for Maryland have consistently run lower than national averages so "some catching up should be expected."

#### ***Consumer group pushing for drug pricing transparency next session***

The Maryland Citizens' Health Initiative consumer advocacy group announced last week that they will seek a ballot referendum next session that would force drug manufacturers to disclose how they set prices for generic and specialty medications, citing an OpinionWorks poll showing that it would be supported by more than 80 percent of Maryland voters across the political spectrum.

The measure would be based on drug pricing transparency legislation introduced this year in ten other states. Only Vermont has enacted such legislation (see Update for Week of June 20<sup>th</sup>) and the initiative in California that drew the most attention (and pharmaceutical opposition) was recently withdrawn (see Update for Week of August 15<sup>th</sup>).

#### Massachusetts

#### ***Commonwealth makes progress in meeting landmark cost containment mandate***

The annual report issued last week by the state-operated Center for Health Information and Analysis shows that the Commonwealth's landmark cost containment law is helping to moderate the growth of health care spending.



Researchers found that health care spending fell from 4.2 percent in 2014 to 3.9 percent last year, matching the economic growth rate for the state and remaining below the 4.6 percent national rate of increase. However, the 3.9 percent figure is still 0.3 percent above the target growth rate set by the 2012 law signed by then Governor Deval Patrick (D), which created the Center and charged it with monitoring the Commonwealth's health care spending (see Update for Weeks of July 23 and 30, 2012).

The report largely blamed large health care providers for the Commonwealth's failure to meet its target, noting that the state's largest insurers (Blue Cross Blue Shield of Massachusetts, Harvard Pilgrim Health Care, and Tufts Health Plan) all successfully kept spending increases below the state benchmark despite a 10.1 percent increase in prescription drug costs (down from the 13.5 percent increase in 2014). The 2012 law authorizes the Health Policy Commission to impose sanctions on insurers or providers that exceed the benchmark. However, the Commission has yet to do so.

Researchers did stress that Medicaid spending greatly moderated last year after thousands of enrollees that received temporary coverage in 2014 migrated over to Marketplace coverage. Medicaid spending in 2015 rose only 4.6 percent following the nearly 18 percent spike the year before.

Overall, Massachusetts spent \$8,424 per resident on health care in 2015, which accounts for private health insurance expenditures in addition to public programs like Medicare and Medicaid.

Massachusetts continues to be the only state that sets some form of cap on health spending. The 2012 law has encouraged providers to use global budgets, where they receive a capitated amount per year but given more control over spending. Other provisions of the law have put alternative payment plans into place for commercial health insurers.

#### Missouri

##### ***Legislature overrides veto of provider price transparency law***

Both chambers provide the two-thirds majority this week that was needed to override the veto of S.B. 608 issued last July by Governor Jay Nixon (D).

Starting July 1, 2017, S.B. 608 will require all licensed health care providers in the state to provide consumers with an estimate of the cost of a particular service or procedure within three business days of a written request. The estimate must include only those services within the direct control of the provider and the amount that the patient will be charged without a public or private third-party paying for any portion.

The provisions notably do not apply to charges for hospital emergency departments.

Providers may choose to publicly post this information on a website in lieu of having to respond to written estimate requests. However, they are required to publicly post the amount charged (without discounts) for each of the 100 most prevalent diagnosis-related groups under Medicare.

Governor Nixon had vetoed the bill for reasons unrelated to the transparency provisions. In his veto message, the Governor specifically objected to "cruel and punitive" fees that the Republican-controlled legislature forced Medicaid enrollees to incur for missing or rescheduling appointments without 24-hour notice.

#### Montana

##### ***Insurance commissioner deems Blue Cross Blue Shield rate hike to be "unreasonable"***

The commissioner of the Department of Securities and Insurance Monica Lindeen (D) announced this week that an extensive rate review process has shown that proposed Marketplace premiums for Blue Cross and Blue Shield (BCBS) of Montana to be "unreasonable" as they were not warranted based on actuarial data.



The declaration was the first time that the Department has issued such a finding and followed a series of public hearings into the staggering 65.4 percent average rate hike sought by the state's dominant insurer. In response to public opposition, BCBS had agreed to slightly downgrade its rate hike proposal to a 58.4 percent. However, Commissioner Linden still found that the proposed increase for 2017 still went "beyond [the] goal" of "[charging] premiums high enough to pay all their claims and stay in business."

BCBS has challenged the finding and refused to waive the 30-day confidentiality period afforded by state law. As a result, the bases for the decision will not be made public until September 19<sup>th</sup>.

The Commissioner noted that the two other insurers offering individual coverage in the Affordable Care Act (ACA) Marketplace were seeking far lower premium increases. Pacific Source has proposed a 27.6 percent average rate hike while the Montana Health CO-OP is seeking a 30.7 average increase. The CO-OP is one of only six of the 23 non-profit cooperatives created with ACA loans that remain in operation (see below).

#### New Jersey

#### ***Health Republic closure leaves only six remaining CO-OPs nationwide***

The Department of Banking and Insurance announced this week that Health Republic Insurance of New Jersey will be removed from the health insurance Marketplace operated pursuant to the Affordable Care Act (ACA).

Health Republic will continue to serve its existing 35,000 subscribers through the end of 2016, at which point the Department will assist them in finding other coverage. Commissioner Richard Badolato stated that Health Republic would enter into a "rehabilitation" plan to preserve their financial assets and ensure providers will continue to be reimbursed through 2016.

The decision was due to Health Republic's "deteriorating financial condition" brought on by the \$46.3 million payment it is required to make to other insurers under the ACA's risk corridors program (see above). Health Republic had anticipated that it would only need to pay \$17 million.

The rehabilitation plan put in place by the Department is designed to allow Health Republic to remain afloat while this payment is challenged or modified (see above). Health Republic stated this week that it intends to return to the Marketplace in 2018.

Health Republic's withdrawal comes only one week after another start-up, Oscar Insurance Corporation, decided to exit the Marketplace in New Jersey next year (see Update for Week of August 22<sup>nd</sup>). Their departure leaves the New Jersey Marketplace with only two insurers for 2017. However, both Horizon Blue Cross and Blue Shield and AmeriHealth already control more than 80 percent of individual Marketplace enrollees in New Jersey.

#### Ohio

#### ***CMS rejects Governor's plan to charge premiums for lowest-income Medicaid expansion enrollees***

The Centers for Medicare and Medicaid Services (CMS) has denied the waiver sought by Governor John Kasich (R) that would impose premiums on the full Medicaid expansion population and terminated coverage for those that failed to pay.

Governor Kasich had made Ohio the first Republican-controlled state to expand Medicaid under the Affordable Care Act (ACA) when he used a legislative maneuver to circumvent opposition from conservative lawmakers, allowing more than 600,000 Ohioans to subsequently gain coverage (see Update for Week of October 21, 2013). His proposal sought to curry favor among those lawmakers by



imposing requirements favored among conservatives, including a requirement that expansion enrollees above and below the federal poverty level (FPL) pay two percent of their income (up to \$99 per year) into a health savings account used to pay premiums. Those who fell more than 60 days behinds on their payments would be dropped from the program and not permitted to re-enroll until their outstanding balance was paid.

In a letter sent last week to state officials, CMS acting Administrator Andy Slavitt noted that Ohio's own Medicaid program acknowledged that the new premium requirements would cause more than 125,000 enrollees per year to lose coverage and insisted that they would undermine the ACA's goals of access and affordability.

CMS has yet to approve any Medicaid expansion waiver that allows enrolls earning below FPL to have their coverage terminated for premium non-payment (see Update for Weeks of January 26 and February 2, 2015). Two other states with existing Medicaid expansions (Arizona and Kentucky) have similar requests pending with CMS.

#### Washington

#### ***Marketplace board approves only a four percent average rate hike***

The governing board for the health insurance Marketplace that Washington operates pursuant to the Affordable Care Act (ACA) approved final 2017 premiums this week for seven of the nine participating insurers.

The average increase of only four percent pales in comparison to average rate hikes in Connecticut, Maryland, and Massachusetts that have exceeded 20 percent (see above). This highest increases were granted for gold tier plans (9.9 percent) as their average deductibles will actually decline by eight percent. By contrast, the most popular silver tier plans received an average premium increase of less than one percent because of average deductible that are jumping by more than 14 percent.

#### Wisconsin

#### ***Insurance commissioner will defy CMS rules on re-assigned Marketplace subscribers***

Insurance Commissioner Ted Nickel (R) notified the Centers for Medicare and Medicaid Services (CMS) late last month that will not allow consumers to be automatically re-enrolled in other Marketplace coverage if their participating insurer exits the Marketplace.

In his letter to CMS, Commissioner Nickel insisted that CMS regulations allowing such re-assignment violates Wisconsin law and lacks any statutory authority under the Affordable Care Act. As a result, he threatened to impose sanctions on any Marketplace insurers that accept premium payments from a re-assigned subscriber and seek "restitution" for any harm that consumers may experience.