Health Reform Update – Weeks of April 28 and May 5, 2014

CONGRESS

House passes reworked bill to exempt expatriate health plans from ACA mandates

The House passed a measure this week that would permanently exempt expatriate health plans from the individual and employer mandates under the Affordable Care Act (ACA).

The Internal Revenue Service (IRS) already exempts most health plans for Americans working abroad from both mandates, but only through 2017 (see Update for Week of March 31st). Rep. John Carney (D-DE) sponsored the bill (H.R. 4414) insisting that American insurance companies would be at a competitive disadvantage versus foreign counterparts if the exemptions were not made permanent.

Despite the support of 52 House Democrats, H.R. 4414 is not expected to be considered by the Senate. The White House opposes the bill, claiming it would "reduce consumer protections and create even more loopholes in the tax code."

A broader version received a majority of House votes last month but failed to obtain the three-fourths majority needed to pass under a suspension of House rules. In order to address concerns raised during that debate (in which 20 Republicans voted against the measure), the latest version of H.R. 4144 narrowed the definition of an expatriate plan to workers that have been abroad for at least six months (instead of three) and travel outside the country at least 15 times in one year. The same rule would apply to families and to foreigners who spend an equivalent amount of time in the United States.

Insurers tell House panel that at least 80 percent of Marketplace enrollees have paid premiums

Four major health insurers informed the House Energy and Commerce oversight and investigations subcommittee that at least 80 percent of those enrolled in their Affordable Care Act (ACA) Marketplace plans have already paid their first premiums.

The figure reached as high as 90 percent for Wellpoint's Marketplace plans, which were offered in 14 states for 2014. Aetna, Blue Cross and Blue Shield, and Health Care Service Corporation reported that 80-85 percent of subscribers have paid. (Cigna did not yet have figures available).

Republican leaders on Energy and Commerce had released a study in advance of the hearing claiming that only two-thirds of Marketplace subscribers have paid plan premiums. However, the five insurers noted that those findings were misleading because it included the 30 percent of enrollees that had not yet reach their payment deadlines after federally-facilitated Marketplaces and many state counterparts extended enrollment deadlines for those unable to complete applications due to technological glitches (see Update for Week of April 7th).

Republicans offer little opposition to appointee for HHS Secretary

The Obama Administration's appointee to serve as the new Secretary for the Department of Health and Human Services faced tough questions this week about Affordable Care Act (ACA) implementation, but appeared very likely to be confirmed.

Sylvia Burwell received unanimous Senate confirmation just last year for her current post as the director of the Office of Management and Budget (OMB). During her appearance this week before the Senate Health, Education, Labor, and Pensions (HELP) committee, Burwell was praised by several

Republican Senators, in particular for her work heading non-profit charities like the WalMart Foundation. She also received strong support from America's Health Insurance Plans (AHIP).

Burwell stated that as HHS Secretary one of her priorities would be to urge Congress to fund the State Children's Health Insurance Program (SCHIP) through 2019 as authorized by the ACA. Congress has yet to fund the program past October 2015.

Gallup finds sharp drop in uninsured over last part of open enrollment period

The latest polling data released this week by Gallup showed that only 13.4 percent of those surveyed in April report being uninsured, a sharp drop from the 15.6 percent recorded in March which was already the lowest level reported since Gallup started measuring in 2008 (see Update for Week of April 14th).

The decline was most precipitous among African Americans, whose uninsured rate plummeted by more than a third from 20.9 percent in the fourth quarter to 13.8 percent in April.

According to Gallup, the overall drop of 4.6 percent since the fourth quarter of 2013 represents roughly ten million Americans that have gained health insurance. The Congressional Budget Office's latest estimate projects that the ACA will result in a net of 12 million more people insured in 2014, with that number jumping sharply again next year (see Update for Week of April 21st).

FEDERAL AGENCIES

Marketplace enrollment exceeded projections by 115 percent

Nearly 3.8 million consumers (including 1.2 million adults age 18-34) signed-up for Marketplace coverage from March 2nd to April 19th—more than enrolled during the first five months of open enrollment—bringing the total number of enrollees to 8,019,673 according to figures released this week by the Department of Health and Human Services (HHS). Another 4.8 million were enrolled in either Medicaid or the State Children's Health Insurance Program (SCHIP).

The Administration had predicted a late surge based on the experience with other marketplaces such as the Massachusetts Health Connector (see below), Medicare Part D, and the Federal Employees Health Benefit Program (see Update for Week of November 11th). However, the size of the surge in the federal and state Marketplaces surpassed all projections by the Administration and consultants (see Update for Weeks of March 17th and 24th).

According to the Urban Institute, the eight million enrollees by April 19th represent 115 percent of the Administration's projections last fall—a dramatic jump from only 61 percent as of March 1st. As a result, the Marketplaces have already enrolled 46 percent of their 2016 projections and 25 percent of their overall target populations.

By contrast, Rep. Henry Waxman (D-CA) noted that Medicare Part D enrollment only reached 70 percent of its initial target enrollment for the first year.

Enrollment doubled in more than a dozen states over the last six weeks of open enrollment, including states with legislatures opposed to ACA implementation like Florida, Georgia, Tennessee, Texas, and Virginia. A study by Avalere Health found that 22 state or federally-facilitated Marketplaces met or surpassed their specific enrollment targets, with California, Florida, Idaho, and North Carolina far exceeding their initial estimates. However, there remains wide variation nationwide as large states like New York only enrolled 49 percent of their target and the District of Columbia (see below), Hawaii, Maryland, Massachusetts (see below), and New Mexico suffered from enrollment figures that were a

mere fraction of projections. Avalere also cited South Dakota, West Virginia, and Iowa as states that may have difficulty attracting insurers to participate in their Marketplace for 2015 (see below).

California dominated enrollment, signing-up 17.5 percent of all Marketplace enrollees nationwide and more than 50 percent of state-based Marketplace enrollment. Roughly 43 percent of all eligible Californians enrolled in Marketplace coverage. Florida was the next closest at 39 percent and signed-up nearly double the number of consumers as Texas, despite a smaller population.

By the end of open enrollment, 85 percent of those selecting Marketplace coverage qualified for the ACA's premium and cost-sharing assistance (ranging from 16 percent in the District of Columbia and 38 percent in Hawaii to a high of 94 percent in Mississippi). However, 3.6 million were eligible for subsidies and did not select a plan, indicating that coverage may still be too costly.

The 36 federally-facilitated Marketplaces enrolled 5.4 million consumers, while state-based Marketplaces signed-up 2.6 million.

HHS confident in risk pool stability despite low Marketplace enrollment in some states

Department of Health and Human Services (HHS) officials expressed confidence this week that risk pools for all of the state and federally-facilitated Marketplaces were broad enough for 2014 to ensure they will financially viable for 2015.

Nearly half of all young adults that selected a Marketplace plan did so during the last six weeks of open enrollment, bringing in more than 1.2 million younger and often less costly subscribers. While only 28 percent of all overall enrollees were age 18-34, WellPoint and other insurers indicated that their mix of subscribers appeared to hit the "sweet spot" even though it was less than the 38-39 percent figure the industry initially targeted (see Update for Weeks of January 20th and 27th).

A report issued this week by Avalere Health echoed those findings, concluding that "the current age distribution appears to be close enough to plan projections to avoid driving major premium increases." However, Avalere cautioned that age mix varies widely as young adults represent a high of 45 percent in the District of Columbia but only 19 percent in West Virginia.

Avalere also warned that other factors apart from age may still threaten Marketplace viability and put upward pressure on premiums. For example, Hawaii (see Update for Week of April 17th) and the District of Columbia (see below) are among the states that have already sought to increase fees on insurers due to concerns that depressed enrollment due to technological glitches will bring in lower revenue than anticipated.

Cost-sharing for low-end Marketplace plans are double typical employer-based coverage

A report prepared for the Pharmaceutical Research and Manufacturers of America (PhRMA) by Breakway Policy Strategies warns that cost-sharing for the most popular Marketplace plans so far exceeds typical employer-based coverage that it may threaten access to critical drug therapies for subscribers.

Nearly two-thirds of enrollees (65 percent) selected silver-level plans to which premium subsidies are tied while another 20 percent selected the lowest-cost bronze plans. However, the PhRMA study documented that more than half of the 7,027 silver plans in the Marketplaces and nearly all bronze plans combine prescription drugs into the medical deductible.

The combined deductible for silver and bronze plans averages $2,275 and $4,986 respectively, compared to only $470 and $956 for those that have a separate prescription drug deductible. These

require subscribers to pay nearly double the 22 percent of total costs that they typically assume under employer-sponsored coverage, according to the analysis.

The report also documents that average silver and bronze level cost-sharing for the highest-cost specialty tier drugs are also nearly double the $80 that employer-sponsored plans typically impose (though this figure does not distinguish between specialty tier coinsurance where subscribers pay a percentage of the drug cost and specialty tier copayments where they pay a flat fee).

Centers for Medicare and Medicaid Services (CMS) spokespeople responded to the study by pointing out that subscribers now benefit from annual out-of-pocket limits of roughly $6,500 for individuals and $13,000 for families and can no longer be denied for pre-existing conditions.

Federal Marketplaces are a "relative bargain" compared to state-based models

Despite the flawed rollout, a new report this week from the Missouri Insurance Commissioner shows that average costs for the federally-facilitated Marketplaces (FFMs) operating in 36 states were less than half of those states that created their own Marketplace.

The study authored by Jay Angoff, who formerly headed the U.S. Department of Health and Human Services (HHS) office overseeing Marketplace implementation, founds that average costs to sign-up each FFM enrollee were only $647 compared to $1,503 in the state-based Marketplaces (SBMs). Per enrollee costs for the state with the most overall enrollment, California, still came in at $758 per enrollee, the only SBM with per enrollee costs below $1,000.

The worst average costs belong to Hawaii, at $23,8999 per enrollee and Washington, DC with $12,467. Surprisingly, five of the conservative-learning states that most adamantly opposed ACA implementation (Florida, Texas, Georgia, Virginia, and Michigan) were the most efficient (ranging from just $76 per enrollee in Florida to $427 in Michigan).

Angoff acknowledged that states with relatively small populations simply could not spread out the hundreds of millions they received in grant funding among as many enrollees, which is why Hawaii and Washington, DC led the list. However, the study did show that SBMs like New York did far better at using the grant funding to enrollee a larger percentage of their eligible population.

Few have sought exemptions from individual mandate under ACA

The Centers for Medicare and Medicaid Services (CMS) announced this week that only about 77,000 families and individuals have requested exemptions from the controversial individual mandate under the Affordable Care Act (ACA), well below the 12 million that the Obama Administration predicted would apply by 2016.

Under the ACA, anyone with incomes below the tax filing threshold or those for whom the lowest cost health plan option would exceed eight percent of annual income are automatically exempt from the requirement to buy minimum essential coverage. The law and subsequent regulations created 14 other categories of exemptions, including those for certain religious groups, Native Americans, undocumented immigrants, and others claiming hardship.

As of April 20th, CMS has already approved roughly 26,000 of the 77,000 exemption requests without a single rejection. More than 32,000 of exemption applications have been from those belonging to Native American tribes, who already receive their care through the federal Indian Health Service. (However, leaders of Indian groups acknowledge that many ultimately apply for Marketplace coverage when they realize it offers better benefits). Another 11,000 applications are from Amish and Mennonite groups that are already exempt from Medicare and Social Security.

Roughly 11,400 applications are for a "general hardship" exemption that includes those ineligible for Medicaid or ACA subsidies after their state opted-out of the ACA's Medicaid expansion. Kaiser Family Foundation has estimated that roughly 7.6 million Americans may fall into this category, for whom the Obama Administration granted an exemption after the U.S. Supreme Court allowed states to opt-out without penalty (see Update for Week of August 6 and 13, 2012). However, CMS acknowledges that most individuals that fall into this "coverage gap" created by opt-out states will already be automatically exempt because they earn below the tax filing threshold.

CMS broadens special enrollment period for Marketplace plans

The Centers for Medicare and Medicaid Services (CMS) issued a May 2nd bulletin broadening the number of individuals that may qualify for an exemption allowing them to purchase Marketplace coverage outside of annual open enrollment periods.

The exemption now includes those that are eligible for COBRA coverage (see below), those whose plans will renew outside of the open enrollment periods, and those that participate in national service programs, such as AmeriCorps. In addition, CMS created a temporary hardship exemption from the ACA's individual mandate for those that purchased Marketplace coverage that was not effective until May 1st. The automatic exemption does not require an application but applies only to Marketplace coverage. As a result of the exemption, individuals with Marketplace coverage as of May 1st will not incur a tax penalty for not having minimum essential coverage during April.

Proposed rules create special enrollment period for COBRA-eligible employees

The Centers for Medicare and Medicaid Services (CMS) and Department of Labor (DOL) issued proposed rules last week creating a 60-day special enrollment period (SEP) from May 2nd to July 1st for those enrolled in or eligible for COBRA continuation of their employer-based coverage.

The rules set-up a mechanism for those whose existing COBRA policies end outside of the open enrollment period to enroll in federally-facilitated Marketplace (FFM) coverage, whether or not they were aware that they had access to a Marketplace plan. They also now require employers to include information about Marketplace plans in their notice of COBRA coverage options that must be provided to all employees when their leave their jobs.

The newly-created SEP is separate from the SEP that DOL already requires once COBRA coverage is exhausted.

Commentators immediately noted that employees earning from 100-400 percent of the federal poverty level should find Marketplace plans to be more affordable than COBRA coverage because they will be eligible for premium and cost-sharing subsidies under the Affordable Care Act (ACA). By contrast, those electing COBRA coverage must pay both the employee and employer share of the premium, making COBRA continuation cost- prohibitive for most individuals in that income bracket.

However, commentators also stressed that those remaining in COBRA will have access to the same network of providers as their employer-based plan, whereas Marketplace plans will often have narrower provider networks (see Update for Weeks of March 17th and 24th).

CMS also created a large-scale SEP for consumers with individual market plans that are ending outside of the 2015 open enrollment period. The rules note that CMS is taking this action because it recognizes that consumers may have "reasonably expected" to have the option not to renew non-calendar year plans and instead to have been able to shop for Marketplace coverage. Under the proposed rule, affected individuals may now report to the FFM that they will not renew a plan up to 60 days before the renewal date and can get coverage in the FFM effective the first of the month following that date.

Although the rules apply only to the 36 states where CMS fully or partially operates the FFM, the agency encourages state-based Marketplaces to adopt a similar SEP.

STATES

California

Medi-Cal application backlog grows to 900,000 as state prioritizes Marketplace enrollment

About 900,000 California residents that applied for the state's expanded Medicaid program are still waiting to be approved due to software glitches in the eligibility system, according to a non-profit journalism project funded by The California Endowment.

HealthyCal blames the backlog on the decision by Department of Health Care Services (DHS) officials to put a priority on qualified health plan (QHP) enrollment in Covered California. The state's version of the Affordable Care Act (ACA) health insurance Marketplace was the most successful in the nation, enrolling more than 1.4 Californians during the inaugural open enrollment period (see Update for Week of April 21st).

While initial glitches in QHP enrollment have largely been resolved, the portion of the Marketplace designed to determine whether applicants were Medicaid-eligible was not available until January 21st and was missing features included in the system that processed QHP enrollment (see Update for Week of January 6th). According to HealthyCal, many of the problems with the Medicaid eligibility system remain uncorrected.

As a result, the backlog of Medicaid applications jumped by 100,000 during the late enrollment surge in April.

DHS officials acknowledge that short timelines handed down by the Obama Administration forced them to put Medicaid applications on the back burner but insist that they are focusing on reducing the backlog now that open enrollment for QHP plans has closed. They emphasize that roughly 1.9 million Californians have gained Medicaid coverage as of March 31st.

Success of California's individual Marketplace has not translated to small group version

Only a small percentage of small businesses in California have enrolled in coverage through the state's small business health insurance Marketplace.

Covered California formally launched the Small Business Health Options Program (SHOP) in December, two months after open enrollment began for the individual Marketplace. Immediate technical glitches forced the SHOP web portal offline in February, and applicants have since only been able to enroll by phone or through insurance agents and brokers.

As a result, only about 1,200 of California's 700,000 small businesses have enrolled in SHOP plans, compared to the nation leading 1.4 million enrolled in individual Marketplace plans (see Update for Week of April 21st).

Health committee approves bill limiting prescription drug cost-sharing

The Assembly Health Committee passed A.B. 1917 this week, which would require (starting in 2016) that cost-sharing for covered outpatient prescription drugs not exceed 1/24 of the annual out-of-pocket limit for an individual prescription or supply of up to 30 days. The bill would also require that an enrollee who is eligible for a reduction in cost sharing through a qualified health plan offered through an

Affordable Care Act (ACA) Marketplace not be required to pay in any single month more than 1⁄24 of the annual limit on out-of-pocket expenses for that product limit for a drug that does not have a time-limited course of treatment or that has a time-limited course of treatment of more than three months. For a drug that has a time-limited course of treatment of three months or less, A.B. 1917 would require that the cost-sharing not exceed 1⁄2 of the annual out-of-pocket limit.

The measure now moves to the Assembly Appropriations Committee.

Colorado

Insurance division extends ACA-deficient plans through 2015

The Division of Insurance announced this week that it will allow insurers to continue offering health plans for individuals and small groups that do not comply with the new consumer protections under the Affordable Care Act (ACA), at least through 2015.

The Division elected to exercise the discretion granted by the Obama Administration to extend ACA-deficient plans until 2017, as it did for states defaulting to the federally-facilitated Marketplace (FFM). About 335,000 individual and small group policies in Colorado were canceled last fall because the plans failed to meet the ACA's coverage requirements. Roughly 92 percent of those with canceled policies received early renewal offers, but most were good only for 2014.

The Illinois Department of Insurance made a similar announcement this week.

Insurance commissioner announces rate relief plan for mountain resorts

Insurance Commissioner Marguerite Salazar (D) unveiled a new health insurance rating plan last week that seeks to lower Marketplace premiums for resident of mountain resort counties that are the highest in the nation.

Colorado currently has 11 rating areas, but four counties in resort areas all are group as one. Because of their large numbers of temporary workers, these resort areas have some of the highest uninsured rates in the nation (Summit County alone ranks 17th worst). As a result, their 2014 premiums under Connect for Health Colorado were up to three times higher than any other parts of the state (see Update for Week of October 21st)..

Due to this cost, Congressman Jared Polis (D-CO) had been pushing for a federal waiver that would at least exempt residents from these resort areas from the individual mandate under the Affordable Care Act (ACA) (if they did not meet the existing threshold for the affordability exemption). Commissioner Salazar was already under pressure from state lawmakers to act.

The Commissioner's new proposal would group all the western Colorado counties together except for Mesa County on the edge of the state, and separately group all the rural counties on the eastern plains and southern parts of the state. The changes will lower the rates charged to residents in resort counties by roughly 4-8 percent but likely increase premiums for residents of other rural areas by 4-6 percent. She stressed that western counties could see even lower rates if Kaiser Permanente follows through on their pledge to expand that part of the state by 2016.

District of Columbia

Council imposes fee on all insurers to keep Marketplace viable

The D.C. Council unanimously approved a one percent tax this week on all health insurance premiums for plans sold in the District in order to boost revenue for the Affordable Care Act (ACA) Marketplace.

Even though the measure will ultimately require Congressional review, it will take effect on an emergency basis. Insurers immediately threatened a lawsuit, insisting that applying the tax to non-Marketplace plans overstepped the intent of the ACA.

The District's Marketplace web portal suffered from the same technological glitches that initially plagued the federally-facilitated Marketplaces (FFMs) and continues to depress enrollment in several state-based models. With enrollment far below initial projections, the District was faced with the choice of imposing a whopping 17 percent fee on insurers participating insurers in order to meet its $28 million annual budget or spreading out the tax on all insurers in the District.

Florida

Final phase of statewide Medicaid managed care expansion goes into effect

The Agency for Health Care Administration (AHCA) launched the Managed Medical Assistance program last week, which is the second and final installment of Florida's Statewide Medicaid Managed Care (SMMC) program. SMMC moves 85 percent of Medicaid enrollees in all counties into mandatory managed care plans, instead of the five-county demonstration in effect since 2006.

The first segment, covering long-term care services for aged and disabled adults and children, was rolled out statewide from August 1, 2013 to March 1, 2014. The second stage will be phased-in starting with Medicaid regions 2-4 this month, followed by Regions 5,6, and 8 in June, 10 and 11 in July, and 7 and 9 in August. Details are available on the newly-created SMMC website at http://ahca.myflorida.com/SMMC.

The initial five-county pilot program was beset by disruptions in access and quality as plans skimped on care to stay within capitated payments (see Update for Week of April 4, 2011). However, the Obama Administration agreed to the statewide expansion after Florida adopted a number of "unprecedented consumer protections", including a medical-loss ratio (MLR) similar to that required under the Affordable Care Act whereby participating plans must spend at least 85 percent of premium revenue on direct medical care (see Update for Week of June 17th).

Georgia

Governor signs two "impediments to Obamacare"

Governor Nathan Deal (R) signed two measures this week that bill sponsor Rep. Jason Spencer (R) declared would make Georgia the lead state in "throw[ing] sand in the gears of Obamacare"

H.B. 943 initially sought to ban the Georgia Insurance Commissioner from enforcing the new consumer protections under the ACA, including the prohibition on insurers denying coverage for pre-existing conditions. It was eventually narrowed to completely halt the navigator program operated by the University of Georgia that helps facilitate enrollment in the federally-facilitated Marketplace (FFM). It was intended to work in tandem with a separate bill signed by Governor Deal (H.B. 990) that bars state officials from expanding Medicaid without legislative approval, a measure intended to prevent any future Democratic governor from participating in the ACA Medicaid expansion via executive order (see Update for Week of April 21st).

H.B. 943 specifically prohibits any state entity from expending money or assets to even advocate or intend to influence citizens to support Medicaid expansion, an apparent effort to discourage a ballot referendum on the issue that has been sought in other states.

Despite these efforts to hinder implementation, Georgia was one of a dozen states where Marketplace sign-ups doubled over the last six weeks of open enrollment.

Louisiana

Specialty tier bill clears Senate and first House committee

The House Insurance Committee unanimously passed S.B. 165 this week, only one week after it cleared the full Senate with only one dissenting vote (see Update for Week of April 21st). The measure would limit coinsurance or copayments applied to drugs on a specialty tier to not more than $150 per month for each specialty drug or up to a 30-day supply of any single drug.

Floor amendments made clear that such limit is to be inclusive of any copayment or coinsurance and apply after any deductible and until the individual's maximum out-of-pocket limit has been reached. The measure was previously amended by the Senate Insurance Committee to remove prohibitions on specialty tier coinsurance and out-of-pocket limits for prescription drugs that were in the original version (see Update for Week of February 24th).

Maryland

Governor signs legislation limiting cost-sharing for specialty tier drugs

Governor Martin O'Malley (D) signed H.B. 761 this week, which prohibits health plans from imposing a copayment or coinsurance for covered specialty drugs that exceeds $150 for up to a 30-day supply (adjusted for medical care inflation), starting January 1, 2016 (see Update for Weeks of March 17th and 24th). The same limit was enacted last year in Delaware (see Update for July 15th-August 2nd).

Massachusetts

Massachusetts becomes third state to scrap ACA website

The board of the Massachusetts Health Connector voted this week to purchase new software to replace the flawed upgrades to its existing health insurance Marketplace that were required by the Affordable Care Act (ACA).

The new information technology infrastructure will be built by hCentive, which also developed successful state-based Marketplaces (SBMs) for Colorado, Kentucky and New York. However, the Connector will simultaneously prepare to temporarily transition to the federally-facilitated Marketplace (FFM) in the event that the new system does not appear by July to be completed before the November 15th start of open enrollment.

The Connector was created under Massachusetts' landmark health system overhaul in 2007 and became the model for the ACA Marketplaces. It required only upgrades to meet ACA standards. However, Massachusetts relied on the same contractor (CGI Federal) that botched the rollout of the FFMs, resulting in continued technological glitches that severely depressed initial enrollment in 2014 (see Update for Week of February 17th). The Connector enrolled less than 32,000 consumers according to figures released this week by the Obama Administration (see above).

Several board members were joined by the Massachusetts Association of Health Plans in expressing concerns about the $121 million cost to replace the flawed software, as well as the "complexity" of developing a state and federal system at the same time. Insurers largely want Massachusetts to stick with the state-based model that they have known since 2007, instead of defaulting to the FFM, even for just one year.

Massachusetts becomes the third SBM to scrap its existing model due to technological flaws. Oregon recently decided to default to the FFM (see Update for Week of April 21st) while Maryland will rely on software from Connecticut's successful SBM (see Update for Weeks of March 17th and 24th). All three states are the subject of ongoing federal audits and investigations reviewing how they spent federal grants that were used to develop the failed technology (see Update for Weeks of March 17th and 24th).

The Department of Insurance separately announced this week that the Obama Administration has granted Massachusetts insurers a one-year extension to comply with ACA rating factors for the small group market. For the coming year, insurers can continue to use rating factors such as group size or industry when developing rates, but will then be limited to varying rates only for age, geography, family size and tobacco status.

Study shows that expanding health coverage saved lives in Massachusetts

A new report published this week in the *Annals of Internal Medicine* documents that Massachusetts' landmark coverage expansion in 2006 directly correlated to a "robust" decline in the commonwealth's death rate among adults aged 20-64.

The health reform law signed into law by then Governor Mitt Romney (R) became the model for the Affordable Care Act (ACA). As with the ACA, it imposed a tax penalty on individuals that failed to purchase minimum essential coverage they can afford and likewise expanded Medicaid.

The study compared death rates from 2001-2005 with those from 2007-2010. It found that for for every 830 people who became insured as a result of Massachusetts' individual mandate and Medicaid expansion, they calculated, one fewer person died each year. This translated into a three percent decline in the death rate after only the first four years of implementation. Coverage of screening for certain types of cancer, heart disease, infections, and other treatable conditions were largely credited with this decline.

Pennsylvania

Democratic lawmaker seeks to force Medicaid expansion vote in June

Rep. Pamela DeLissio (D) stated her intent this week to rely on a rarely-used legislative maneuver to try and force a vote on whether Pennsylvania should participate in the Medicaid expansion under the Affordable Care Act (ACA).

The "discharge resolution" is an effort to push through a Democrat-backed expansion bill that has sat in committee for more than a year. It requires 25 House members to sign on, after which any of the signees can call for a vote which will come to the floor with the approval of a bare majority of the House.

Rep. DeLissio intends to pursue the resolution when the House reconvenes in June. Even though Republicans control the House, several key Republicans have favored expansion, forcing Governor Tom Corbett (R) to at least propose a "private sector" expansion alternative similar to the model already federally-approved for Arkansas, Iowa, and Michigan.

However, the Governor's proposal goes further than those states by imposing higher levels of cost-sharing, including employment and wellness requirements, and failing to require wrap-around benefits so that newly-eligible populations covered through Marketplace plans receive comparable coverage to traditional Medicaid . The Obama Administration is expected to modify several of the Governor's proposals, although the Governor indicated this week that "productive" negotiations are moving towards a model that he may still be able to support. The Governor has already agreed to relax several of the provisions he initially proposed (see Update for Week of February 17th).

If Governor Corbett's plan does receive federal approval, it still would not be effective before 2015, leading Rep. DeLissio and other lawmakers to push for legislation that would allow for an earlier expansion. According to the Pennsylvania Health Access Network, the state loses $4.7 million dollars for every day that it does not expand. They also project that the federal matching funds under the ACA will allow Pennsylvania to "generate $522 million in state budget savings at a time when Pennsylvania is facing a $1 billion dollar budget deficit."

Washington

Marketplace set to add four insurers for 2015

Insurance Commissioner Mike Kreidler (D) announced this week that four additional insurers plan to join the Washington Healthplanfinder in 2015, in addition to the eight current insurers that are expected to return to the Affordable Care Act (ACA) Marketplace.

Ten of the 12 insurers plan to offer coverage in and outside of the Marketplace. One of the new entrants, Moda Health Plan, opted not to participate last year after the Insurance Commissioner rejected its application to sell in and out of the Marketplace.

Other new entrants include insurance giant UnitedHealthcare, as well as Health Alliance Northwest Health Plan and Columbia United Providers. Proposed rates are expected to be publicly available by mid-May.

The Insurance Commissioner is requiring all Marketplace insurers to broaden provider networks and plan transparency for 2015, both in and out of the Marketplace. The specific standards for network adequacy will take effect on May 26th.

Four of the 12 insurers that plan to participate in the Washington Healthplanfinder for 2015 are seeking to increase premiums on individual plans by 0.57-14.2, according to preliminary documents filed with the Insurance Commissioner.

Kaiser Foundation Health Plan of the Northwest asked for the lowest increase of only 0.57 percent, while the highest increase is being sought by Group Health Options. Molina Healthcare of Washington actually asked for a 6.8 percent rate cut but only if the annual deductible and out-of-pocket caps can be increased.

The Commissioner in Washington has the authority to modify or reject the proposed rates.