



Health Reform Update – Weeks of October 5 and 12, 2015

CONGRESS

New PSI-backed bill would require Marketplace insurers to accept non-profit premium assistance

At the urging of PSI, Rep. Kevin Cramer (R-ND) introduced legislation last week that would require insurers participating in Affordable Care Act (ACA) Marketplaces to accept premium assistance provided by non-profit charitable organizations.

The *Access to Marketplace Insurance Act* (H.R. 3742) follows a “Dear Colleague” letter sent by Rep. Doris Matsui (D-CA) and 36 other House Democrats urging the Centers for Medicare and Medicaid Services (CMS) to revise last year’s interim final rule that gave Marketplace insurers the discretion to deny third-party premium assistance from charitable groups, while requiring them to accept payments from state and federal health programs like the Ryan White HIV/AIDS Program (see Update for Week of August 10th). Republican lawmakers including Senators David Vitter (R-LA) and Bill Cassidy (R-LA) sent a similar letter last year (see Update for Week of June 2, 2014).

CMS officials have not responded to lawmaker requests to explain the inconsistency between the interim final rule and two earlier guidance documents that specifically allowed “premium payments from private, not-for-profit foundations...that are based on financial status, do not consider enrollees’ health status, and cover the entire policy year.” Since the rule was published, at least 28 insurers in 23 states have refused such assistance and several others have indicated that they will start doing so in 2016 (see Update for Week of May 4th).

PSI Government Relations will be working with Congressional offices in the coming weeks to secure bipartisan cosponsors for this legislation. PSI is also submitting comments emphasizing that denying third-party premium assistance qualifies as prohibited discrimination under new CMS rules as it has “the effect of discouraging enrollment of individuals with significant health needs” and effectively circumvents the ACA mandate for insurers to cover all applicants regardless of health status (see Update for Week of September 28th).

President signs ACA amendment eliminating new definition of small employer

President Obama signed legislation last week that will let states continue to define a small employer as those with 50 or fewer workers. The bill (H.R. 1624) had received strong bipartisan support in both the House and Senate as the Affordable Care Act (ACA) would have expanded the small employer definition next year so that mid-size companies with 51-100 employees would have to start abiding by ACA rules governing the small group market, including essential health benefits, minimum actuarial values, and premium rating restrictions (see Update for Week of September 28th). They would have also been subject to employer mandate penalties for failing to provide minimum essential coverage to workers.

America’s Health Insurance Plans claimed that such a change would have increased premiums by an average of 18 percent for nearly two-thirds of the 3.4 million workers in these mid-sized companies (see Update for Weeks of August 31st and September 7th).

The bill is one of only a handful of ACA amendments that the President has signed and the first since Republicans took control of both chambers earlier this year.

In response to H.R. 1624, the Oregon Insurance Division promptly introduced regulations that would keep that state’s definition of small employer at 50 or fewer workers.



ACA repeal measure heads to the House floor

The House Budget Committee approved a fast-track measure last week on a party line vote that seeks to repeal several provisions of the Affordable Care Act (ACA) through the budget reconciliation process requiring only simple majority in the Senate.

The full House is expected to vote on the bill next week. It incorporates recommendations from the House Ways and Means Committee, which sought to eliminate the controversial individual and employer mandates under the Affordable Care Act (ACA), as well as the law's taxes on medical device manufacturers and high-cost or "Cadillac" health plans (see Update for Week of September 28th). A separate provision would repeal the Independent Payment Advisory Board (IPAB) before the Medicare cost-cutting panel is appointed.

The budget package also includes recommendations from the Energy and Commerce committee to terminate the Prevention and Public Health Fund that eliminates cost-sharing for certain preventive services, as well as the Education and Workforce Committee's proposal to remove the ACA requirement for large employers to automatically enroll new full-time employees in coverage (which has yet to go into effect).

President Obama has pledged to veto the repeal measure and Republicans currently lack the supermajority needed to override such a veto. However, Republican leaders expressed optimism this week that increasing bipartisan support for eliminating the medical device and "Cadillac" taxes, as well as the IPAB, would force the President to reconsider his position on those provisions (see Update for Weeks of September 14th and 21st).

New bills would prevent Medicare Part B premium hikes for 2016

Senate Finance Committee ranking member Ron Wyden (D-OR) introduced legislation last week (S.2148) that would hold Medicare Part B premiums constant for 2016 and avoid a 52 percent spike for certain enrollees. A companion measure (H.R. 3696) was also introduced in the House by Rep. Dana Titus (D-NV).

The increase projected by the Medicare Board of Trustees would apply to the 30 percent of Part B enrollees that are not protected by the "hold-harmless" provision that ensures the dollar increase in the Part B premium cannot exceed the dollar increase of an enrollee's monthly Social Security benefit. Since COLA adjustments are tied to the Consumer Price Index (CPI), the Social Security Administration confirmed this week that recipients will not receive a cost of living adjustment (COLA) for 2016 since the CPI has remained flat over the past year.

Certain Part B enrollees are statutorily excluded from the "hold-harmless" provision, including those eligible for both Medicare and Medicaid, higher-income Part B enrollees, and Medicare enrollees that do not receive Social Security. Both bills would keep the monthly Part B premium and annual deductible constant for this group (at \$104.90 and \$147 respectively).

Social Security recipients have not received a COLA adjustment only three times in the last 40 years—all of which have occurred since 2010. Payments had increased by 1.5 percent in 2014 and 1.7 percent in 2015.

Drugmakers protest limited biologic exclusivity period in trade agreement

The Obama Administration reached an agreement in principle last week on a 12-nation trade deal that includes provisions allowing the participating countries to protect biologic drugs from generic competition for only five years.



The Pharmaceutical Research and Manufacturers of America (PhRMA) and Biotechnology Industry Organization (BIO) had backed earlier versions of the Trans-Pacific Partnership (TPP) agreement that would have extended the 12-year exclusivity period for biologic drugs under the Affordable Care Act (ACA) to other countries and prevented Congress from reducing it (see Update for Week of May 11th). Both groups immediately protested the five-year “compromise”, which is even lower than the seven-year exclusivity period previously sought by President Obama (see Update for Week of March 3, 2014).

The deal, which ultimately requires Congressional approval, also met with opposition from both sides of the aisle. Senator Orrin Hatch (R-UT), who had supported the agreement, called the latest version “woefully short” while Rep. Rosa DeLauro (D-CT), a strident opponent of the agreement, insisted that the Administration was “not being transparent” in secretly negotiating only a five-year exclusivity period.

Patient advocates are still pushing for a more limited exclusivity period insisting that even a five-year wait for lower cost biosimilar competition will “harm public health” in developing countries. They warn that biologic drug manufacturers could simply wait seven years to introduce a drug to the market in a TPP country in order to still get the full 12-years of protection. TPP countries such as Australia and Malaysia had sought the more limited exclusivity period while representatives from the United States and Japan favored the 12-year period for biologics marketed in the United States.

FEDERAL AGENCIES

Premiums for most popular Part D drug plans to see eight percent increase in 2016

A new study from Avalere Health consultants revealed last week that premiums for the ten most popular Medicare Part D prescription drug plans (PDPs) will rise by an average of eight percent for 2016, while five of the top ten plans will see increases from 16-26 percent.

The increase is the greatest in the last five years and will occur despite no increase in average Part D premiums for basic plans (which are currently \$32.50 per month). The top ten PDPs, which cover more than 80 percent of all Part D enrollees, had experience flat growth or premium decreases over the past four years.

Humana blamed specialty drug costs for the 25 percent spike in the average premium for their Humana Enhanced plan (to \$66.25 per month). The largest PDP, MedicareRX Preferred, will see a 21 percent increase (to \$60.79 per month).

The Kaiser Family Foundation released a subsequent study showing that enrollees in stand-alone Part D plans are likely pay 13 percent more in premiums on average if they remain in their current plan for 2016. Enrollees can lower their premiums by switching plans (with 26 stand-alone options for 2016, down from 30 this year). However, nine of ten Part D enrollees remain in their same plan every year.

Kaiser found that more than half (53 percent) of stand-alone plans will require enrollees to meet the standard Part D deductible, the largest share to impose the maximum allowable deductible since the inception of Part D. The standard deductible for 2016 will be \$360 compared to \$320 in 2015.

A report released earlier this year by the Medicare Payment Advisory Commission (MedPAC) warned of rising Part D premiums as fewer big blockbuster drugs have generic alternatives and more than half of new drug approvals are for specialty drugs.



Silver Marketplace plans impose higher drug costs than employer-sponsored coverage

Researchers with Emory University have found that chronically-ill consumers enrolled in plans offered under Affordable Care Act (ACA) Marketplaces incur double the out-of-pocket costs for prescription drugs than those covered under employer-sponsored plans.

The study published last week in *Health Affairs* specifically found that those with at least one chronic illness (such as diabetes) pay an average of \$621 in out-of-pocket drug costs if they are enrolled in the most popular silver-tier Marketplace plans (to which the ACA premium and cost-sharing subsidies are tied). However, those covered through their employer incur only \$304 on average in out-of-pocket drug costs.

Researchers attributed the high deductibles that silver plans typically require as the primary reason for the disparity. As a result, those enrolled in silver plans pay an average of 46 percent of their total drug costs, compared to only 20 percent for employer-sponsored coverage.

The authors stressed the importance of consumers shopping around for the plan with the best overall value, instead of just the lowest premium. They point out that those with chronic conditions will often have lower out-of-pocket costs overall if they enroll in higher premium plans at the gold and platinum level, which have lower deductibles and annual out-of-pocket limits.

STATES

Four more ACA-created insurance cooperatives face liquidation

Kentucky Health Cooperative (KHC), Community Health Alliance (CHA) of Tennessee, and Health Republic of Oregon became the fifth, sixth, and seventh Consumer Oriented and Operated Plans (CO-OPs) to shut down this week, forcing roughly 100,000 subscribers to switch by the end of the year to other plans offered in Affordable Care Act (ACA) Marketplaces.

The non-profit health insurance cooperatives were three of 23 that were created with ACA loans before funding was cut off by Congress as part of bipartisan deficit reduction agreements (see Update for Weeks of December 24 and 31, 2012). The Inspector General for the U.S. Department of Health and Human Services (HHS) found that 21 of the 23 CO-OPs were already losing money as of last summer and unanticipated early enrollment for at least eight of the 23 outpaced their ability to pay claims (see Update for Week of June 1st).

CHA was already in trouble earlier this year after its initial enrollment of 27,000 subscribers outpaced its ability to pay claims with ACA loans (see Update for Week of January 12th). However, it was the recent \$2.5 billion shortfall in risk corridor payments under the ACA that was the final blow for KHC, Health Republic of Oregon, and two earlier failed CO-OPs (see Update for Week of September 28th). This temporary program was intended to compensate Marketplace insurers for the costs of enrolling sicker and more costly patients. However, HHS announced last month that insurers will receive only 12.6 percent of the \$2.87 billion they were slated to receive this year.

Colorado's largest non-profit insurer, Colorado HealthOP, acknowledged last week that it faces a similar fate. The CO-OP used low premiums to attract more than 80,000 subscribers but already faces a net loss of \$23 million. Without the expected help from the ACA risk corridors program, state regulators are expected to shortly decide whether to cease plan operations for 2016.



Study show 4.4 percent increase in average Marketplace premiums for 14 major cities

A report released this week by the Kaiser Family Foundation found that average silver-tier premiums for Marketplaces in 14 major cities will increase by an average of 4.4 percent in 2016.

The survey on final rate data for participating insurers shows that premium increases are well-above 2015, when silver-tier rates for the same 14 cities actually fell by 1.3 percent. However, as with 2015, there continues to a wide variation in premiums, with average 2016 premiums increasing by 28.7 and 22.8 percent in Minneapolis, MN (where some regions will see a nearly 50 percent increase) and Portland, OR respectively, but only one percent or less in Providence, RI, Washington, DC, and New York, NY.

Only four of the 14 cities will see average premiums decline in 2016 (compared to six last year). The largest decrease of 10.4 percent will occur in Seattle, WA, while Marketplace consumers in Los Angeles, CA will see premiums fall by five percent (compared to a 1.2 percent increase last year). Average premiums in Detroit, MI and Hartford, CT will also go down by 1.8 and 1.3 percent respectively.

California

Governor signs ten health-related bills, including measure to limit out-of-pocket drug costs

Governor Jerry Brown (D) signed roughly a dozen health-related bills into law over the past two weeks, led by several consumer protection measures that will require insurers to limit out-of-pocket (OOP) costs for prescription drugs and improve the accuracy of their provider directories.

A.B. 339 applies to non-grandfathered health plans offering outpatient prescription drug coverage on or after January 1, 2017. Under the new law, they must limit cost-sharing to no more than \$250 for a 30-day supply of an individual prescription, or \$500 for bronze tier plans as defined by the Affordable Care Act (ACA)(see Update for Weeks of August 31st and September 7th). These are consistent with those recently adopted by Covered California (see Update for Weeks of May 18th and May 25th), but must be renewed by the legislature to continue past January 1, 2020.

The bill also would prohibit formularies from “discouraging the enrollment of individuals with health conditions and [not reducing] the generosity of the benefit” for a particular condition in a manner that is “not based on a clinical indication or reasonable medical management practices.” This is a change from the initial versions of A.B. 339 that prohibit insurers from moving all or most drugs for a specific condition into drug tiers requiring consumer pay a percentage coinsurance.

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

A.B. 1305 seeks to ensure that individual patients are subject only to the annual out-of-pocket (OOP) maximum set by the ACA for individuals (currently \$6,600), even if they are in a family plan, consistent with the new interpretation of the ACA limits issued earlier this year by the Obama Administration (see Update for Weeks of August 18th and 25th). Senate amendments delayed implementation for the large group market until January 1, 2017.

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



The Governor also signed A.B. 248, which prohibits health plans in the large group market from offering “junk insurance” by requiring that they provide a minimum actuarial value of at least 60 percent. The ACA currently requires that individual and small group plans meet at least this 60 percent threshold, which is equivalent to the lowest-tier bronze plan created by the ACA.

Governor Brown vetoed A.B. 159, which sought to authorize manufacturers of investigational drugs not yet approved by the Food and Drug Administration (FDA) to make those drugs available to patients with medical conditions that are immediately life-threatening. This measure had unanimously cleared both the Assembly and Senate and may be overridden by the legislature.

Governor signs bill expanding Medi-Cal coverage to undocumented children

Governor Jerry Brown (D) signed legislation this week that extends Medi-Cal coverage to low-income children of undocumented immigrants.

Starting next May, the Medi-Cal expansion will apply to roughly 170,000 children under age 19. It is expected to cost the state \$40 million for the upcoming fiscal year and about \$132 million per year thereafter.

The bill (S.B. 4) initially would have required that California seek a federal waiver to allow undocumented adults to purchase coverage through Covered California—since the Affordable Care Act (ACA) currently limits Marketplace eligibility to those with legal immigration status. However, bill sponsor Senator Ricardo Lara (D) was forced to remove that provision in order to secure passage of S.B. 4. He has pledged to pursue that provision next year through S.B. 10 (see Update for Weeks of August 31st and September 7th).

The bill’s signing comes as a new Kaiser Family Foundation report found that 53 percent of all uninsured Californians qualify for either Medicaid coverage or ACA subsidies to help purchase Marketplace coverage. More than half of the nearly 1.8 million uninsured residents who do not qualify for either Medicaid or subsidies are ineligible due solely to their immigration status.

Governor signs biosimilar substitution law despite earlier veto

Governor Jerry Brown (D) made California the 18th state last week to enact legislation limiting the substitution of biosimilar drugs for their brand-name biologics, despite vetoing a similar bill in 2013.

The Affordable Care Act (ACA) created the regulatory pathway for biosimilar approvals and the Food and Drug Administration (FDA) used it to approve the first biosimilar earlier this year (see Update for Weeks of March 2nd and 9th). While the agency has issued some guidance on the biosimilar approval process, stakeholders are still waiting for FDA’s guidance defining when biosimilar drugs can be deemed “interchangeable” with their reference product (see Update for Weeks of April 6th and 13th).

In the absence of this guidance, the issue of interchangeability remains up to state discretion. Eight states passed a variety of substitution bills in 2013 and 2014 but at least ten others including California refused to do so, citing concerns about the measures restricting generic competition to more costly drug versions (see Update for Week of January 19th). As a result, the Biotechnology Industry Organization (BIO) and the Generic Pharmaceutical Association (GPhA) created the compromise language that Puerto Rico and at least ten states including California have since used as a template for their legislation (a New Jersey bill is awaiting action from the governor).

The compromise language requires prescribers be notified whenever pharmacists substitute lower-cost biosimilars that are deemed interchangeable with the name-brand biologic. The compromise specifically includes a provision stating that a pharmacist may communicate the substitution via interoperable electronic health records or electronic prescribing technology. If there is no electronic



record or system that can be accessed by both the pharmacist and prescriber, the pharmacist would communicate the substitution “using facsimile, telephone, electronic transmission, or other prevailing means.”

Governor Brown did not issue a signing statement explaining why he signed this measure (S.B. 671) but vetoed the 2013 bill (S.B. 598). However, he had stated that while he supported the goals of S.B. 598 he believed the legislation to be “premature” (see Update for Week of October 14, 2013).

Covered California surpasses two million consumers

Covered California released updated enrollment figures this week showing that the Marketplace created pursuant to the Affordable Care Act (ACA) has signed-up more than two million consumers in its first two years.

As of June 30th, Covered California had just over 1.3 million active enrollees, putting it slightly ahead of fiscal year 2014-2015 projections and retaking the lead from Florida as the nation’s largest Marketplace. Even though the second open enrollment period closed in February, Covered California continues to enroll an average of 40,000 consumers per month through special enrollment periods, far exceeding the projection of 25,000 per month.

According to the new report, the average Covered California consumer saves 70 percent of their monthly premium due to premium and cost-sharing subsidies provided by the ACA. In addition, 85 percent of consumers that move on from Covered California remain insured under other coverage.

Due to the addition of two new insurers to Covered California (United Healthcare and Oscar Health Plan), as well as expanded coverage areas for three existing carriers, 99.6 percent of consumers will have at least three plans to choose from in 2016 (see Update for Week of July 20th).

Blue Shield agrees to state request to further limit premiums, recalculate rebates

Blue Shield of California has agreed to limit 2016 premium increases for individual and small group plans to an average of 4.6 percent.

The move was in response to “significant concerns” raised by the Department of Managed Health Care to the plans “projected trends and target profit levels.” Under the negotiated order issued this week by the agency, Blue Shield will also limit premium increases to a 1.41 percent profit margin cap for 2017, and a comparable 1.67 percent cap for small groups. It will affect roughly 570,000 subscribers.

Blue Shield also agreed to review its medical loss ratio (MLR) calculations for 2015 and 2016, after the insurer failed to meet the Affordable Care Act (ACA) requirement to spend at least 80 percent of premium revenue on direct medical care. More than 450,000 individual market consumers received an average rebate this year of \$136 because Blue Shield spent only 76.8 percent of premium revenue on medical care (see Update for Weeks of July 27th and August 3rd). Blue Shield will recalculate their figures by April 30th and issue additional rebates by August 1st if the new MLR remains below 80 percent.

State regulators have heightened their scrutiny of Blue Shield after the Franchise Tax Board determined that the company was failing to use its unlawful and “extraordinarily high surpluses” of more than \$4 billion to make coverage more affordable (see Update for Week of March 16th). It has already stripped Blue Shield of its non-profit tax exemption, which will result in billions of dollars in additional consumer rebates if upheld on appeal.

Florida

CIGNA blames fraud for decision to abruptly exit ACA Marketplace



CIGNA informed state regulators and subscribers this week that it would not participate in Florida's federally-facilitated Marketplace for 2015, citing an "exponential increase in fraudulent and abusive delivery practices" for "out-of-network substance abuse clinics and labs."

The late decision will force roughly 30,000 subscribers covered under CIGNA Marketplace plans for 2015 to seek other coverage when the annual open enrollment period starts November 1st. CIGNA had offered seven plan options through the Marketplace this year, mostly in the central Florida, Tampa Bay, and coastal southeast Florida areas.

CIGNA claimed that the magnitude of the fraudulent practices was revealed only after the insurer had submitted its application to participate in the Marketplace for 2016. They include kickbacks and excessive testing by certain clinics and labs. CIGNA insisted that it had no alternative but to exit the Marketplace after the Obama Administration refused to allow them to alter Marketplace plans that they had already approved and certified for 2016.

CIGNA pledged to return to Florida's FFM in 2017 once the fraudulent practices were corrected. It is not immediately clear how CIGNA's decision will impact overall enrollment in Florida's FFM, which enrolled more consumers than any other state during 2015 open enrollment (see Update for Weeks of March 2nd and 9th).

Nebraska

Lack of Marketplace competition results in double-digit rate hikes for 2016

The Department of Insurance released final approved premiums this week for the only two insurers participating in Nebraska's federally-facilitated Marketplace (FFM).

The state's dominant carrier Blue Cross and Blue Shield (BCBS) of Nebraska received nearly a 15 percent average increase while its lone competitor Coventry (a subsidiary of Aetna) will hike premiums by nearly 22 percent on average. The premiums are effective for plans offered during the 2016 open enrollment period that starts November 1st.

Insurance officials acknowledge that the failure of two other participating Marketplace insurers for 2015 contributed to the dramatic spike in premiums. Assurant Health announced last summer that it was exiting the individual health insurance market entirely (see Update for Weeks of June 8th and 15th), while the CoOpportunity Health non-profit cooperative created with Affordable Care Act (ACA) loans was liquidated earlier this year (see Update for Week of January 19th).

CoOpportunity used low premiums to enroll more than 120,000 consumers in Nebraska and neighboring Iowa—second only to the Health Republic cooperative in New York. However, as with Health Republic and two other cooperatives nationwide (see Update for Week of September 28th), CoOpportunity's enrollment far outpaced its ability to pay claims given its limiting ACA funding and it was taken over by the insurance commissioner earlier this year. BCBS Nebraska has been helping CoOpportunity subscribers obtain other coverage.

Insurance officials stressed that despite the nearly 22 percent average rate hike approved for Coventry, the insurer still has lower premiums than BCBS across the board—and that Coventry's 2015 rates were actually lower than 2014. In addition, the entrance of United Healthcare and Medica to the Marketplace for 2016 are expected to bring down premiums for 2017. United Healthcare's premiums for 2016 are lower than both BCBS and Coventry for every plan offering.

More than 74,000 consumers had enrolled in Marketplace plans as of the close of the 2015 open enrollment period, 88 percent of whom were receiving premium subsidies offered by the ACA. However, Insurance officials note that the total enrollment figure fell to under 64,000 by the end of June, due to either a failure to pay premiums or provide documentation verifying their legal immigration status.



New Jersey

Committee rejects bills limiting cost-sharing for prescription drugs

The Pension and Health Benefits Commission rejected House and Senate bills last week that would have required health insurers to limit cost-sharing for prescription drug coverage.

The identical measures (S.3142 and A.4595) sought to place a \$100 per month limit on out-of-pocket costs for a 30-day supply of drugs covered under silver, gold, or platinum plans and a comparable \$200 per month limit on lower-tier bronze coverage (see Update for Week of August 10th).

South Carolina

Marketplace premiums increase by double-digit average despite lower rates for BCBS

State insurance regulators released final approved premiums last week for 2016, showing an average increase of nearly 16 percent for the individual health insurance market.

The average rate hike is only slightly lower for individual plans offered in the federally-facilitated Marketplace operate pursuant to the Affordable Care Act (ACA). The highest increase of 31.8 percent belongs to Coventry (a subsidiary of Aetna), while Consumers Choice had their proposed rate hike actually increased by regulators (from 18.4 percent to 22 percent).

Unlike the trend in other states, the two Blue Cross and Blue Shield (BCBS) plans competing in the Marketplace have the lowest average rate hikes of nearly nine percent. BCBS covers nearly 60 percent of the individual market in South Carolina.

The steepest rate hike of 53 percent was request by Assurant Health. However, Assurant is exiting the individual market nationwide as of January (see Update for Weeks of June 8th and 15th).

Regulators anticipate that the entrance of insurance giant UnitedHealthcare for 2016 will help to moderate rate hikes in coming years (it is joining 11 new Marketplaces next year, up from 24 in 2015 and only four in 2014). However, UnitedHealthcare received a 17.1 percent average rate hike for their non-Marketplace plans.

The individual market rate hikes contrast sharply with the 1.02 percent average increase that regulators approved for the small group Marketplace and two percent increase for the entire small group market.

Utah

Taxes on providers and drugmakers doom Governor's latest Medicaid expansion plan

After months of negotiations between Governor Gary Hebert (R) and Republican leaders, the Governor's latest Medicaid expansion proposal received only seven votes from 63 House Republicans during closed door meetings this week.

Utah Access Plus also fell well short of the 15 votes needed to pass in the Senate, even including votes from Senate Democrats. As a result, the Governor appears unlikely to call a special legislative session later this month to debate the Medicaid expansion alternative model.

Utah Access Plus would have expanded Medicaid under the Affordable Care Act (ACA) to roughly 126,500 Utahns by fiscal year 2017. It planned to use ACA matching funds to purchase private Marketplace coverage for those earning 100-138 percent of the federal poverty level (FPL), who would be subject to monthly premiums similar to federally-approved models in six states (see Update for Weeks of April 6th and 13th).



The Senate approved the Governor's Healthy Utah Plan last session, which would have covered roughly 146,000 Utahns using \$648 million in ACA matching funds and \$78 million in state funds and received tentative approval from the federal government (see Update for Week of December 1st). However, House Republicans insisted that the state share under the ACA (ten percent of annual expansion costs starting in 2020) would balloon to an unsustainable level and would only approve a partial expansion that would cover 93,000 Utahns at a state cost of \$56 million (see Update for Week of February 23rd). Partial expansions are not eligible for ACA matching funds.

In an effort to overcome House opposition, the Governor proposed to pay the state share largely through \$50 million in new taxes on health care providers and drugmakers. Although similar provider taxes were supported by provider associations in conservative states like Arizona and Tennessee, the Governor failed to secure similar support in Utah. The Utah Hospital Association agreed to pay up to \$25 million of the expected state share but only if physicians and pharmaceuticals are required to also "pay their fair share" (see Update for Week of July 20th). However, the latter groups lobbied heavily against the assessment, urging instead that the legislature increase state tobacco taxes.

Wyoming

Marketplace has only one participating insurer for 2016

Blue Cross and Blue Shield (BCBS) will be the only insurer participating in the federally-facilitated Marketplace operated in Wyoming pursuant to the Affordable Care Act (ACA) after WINHealth announced last week that it would not return for 2016.

Roughly 7,500 WINHealth subscribers will have to change to BCBS or other non-Marketplace plans by December 31st after WINHealth decided it no could no longer continue operating without the risk corridor payments under the ACA that compensate insurers for exceptional claims. The Obama Administration announced last month that insurers would only receive 12.6 percent of their expected payments for 2014 claims due to a \$2.5 billion shortfall in the temporary program (see Update for Week of September 28th). As a result, WINHealth will only receive \$638,000 of the \$5 million it had expected in risk corridor compensation.

The shortfall in risk corridor payments has already resulted in the exit of several non-profit insurance cooperatives created by the ACA (see above).