



## Health Reform Update – Week of June 20, 2016

### CONGRESS

#### ***House Republicans release Affordable Care Act replacement plan***

House Republican leaders released a long-awaited plan this week that would replace major provisions of the Affordable Care Act (ACA) but did not include cost estimates for implementation.

The 37-page document largely crafted by Speaker Paul Ryan (R-WI) repeats a number of Republican proposals from prior years, including increases in the retirement age for Medicare and Social Security (to age 67) and the conversion of traditional Medicare into a premium support program. It would create a Medicare Exchange where enrollees can use their premium subsidies to purchase private coverage. The premium support payment would be adjusted by income as well as health status so that sicker enrollees would receive higher payments if their conditions worsened.

Another centerpiece of the plan would combine Medicare Parts A and B, creating a unified deductible, uniform 20 percent cost-sharing for all services, and annual maximum out-of-pocket cap for enrollees, similar to requirements for Medicare Advantage plans.

Starting with fiscal year 2020, Medicare supplemental plans (or Medigap) would be prevented from covering no more than half of the cost-sharing between the deductible and the out-of-pocket cap. The authors of the plan cited Medicare Payment Advisory Commission reports concluding that Medicare spending is 33 percent higher when beneficiaries have Medigap insurance but only 17 percent higher when beneficiaries have job-based coverage.

All consumers would also receive advanceable tax credits to cover "the cost of a typical pre-Obamacare health insurance plan." However, unlike the tax credits offered under the Affordable Care Act (ACA), the Republican plan offers a flat, monthly credit regardless of income. Older Americans would receive larger tax credits to reflect their higher health care costs.

Although the plan would repeal the ACA's individual and employer mandates, it notably retains the law's most popular provisions including the prohibition on pre-existing condition denials and ability for parents to keep adult children on their group plans until age 26. However, it eliminates the ACA's minimum essential health benefit requirements and would allow insurers to charge older consumers up to five times the premium charged to younger consumers (compared to a three times limit under the ACA).

The Republican plan also targets the Independent Payment Advisory Board for repeal, an independent Medicare cost-cutting panel that has yet to go into effect in the face of bipartisan opposition. In addition, it would repeal the Center for Medicare and Medicaid Innovation created by the ACA—the entity responsible for the politically unpopular demonstration that could cut Medicare Part B drug costs (see Update for Week of May 16<sup>th</sup>).

The plan also proposes \$25 billion in federal funding to restore state high-risk pools for consumers with costly conditions that price them out of coverage in the individual market.

Republican leaders stressed that the plan is intended only as a "starting point" and acknowledged that it was not likely to affect policy changes without accompanying cost figures. It expands upon a draft bill released last month by Senator Bill Cassidy (R-LA) and Rep. Pete Sessions (R-TX) (see Update for Week of May 16<sup>th</sup>).



## ***Ways and Means passes series of bills to expand employer mandate exemptions and HSAs***

The House Ways and Means Committee approved a series of bills last week that would make slight changes to the Affordable Care Act (ACA) instead of the repeal of major provisions sought by prior legislation.

The eight bills that are expected to soon move to the House floor include two measures that would exempt specific groups from the employer mandate under the ACA, including tribal-owned businesses (H.R. 3080) and full-time students working for universities (H.R. 210). All Democrats on the panel opposed the former since the bill did not offset the \$119 million cost over ten years. However, the latter passed on a voice vote with Democratic support.

Democrats also praised a measure that would provide small businesses with incentives to purchase coverage in the small group Marketplaces created by the ACA by repealing fines on those that offer employees health savings accounts (H.R. 5447). However, the remaining bills passed largely on party-line votes, with the most heated debate focused on measures that would lower the tax threshold for deducting medical expenses to its pre-ACA level of \$7,500 (H.R. 3590) at a cost of \$32.7 billion over ten years and expand contribution limits for health savings accounts (H.R. 5445).

## **FEDERAL AGENCIES**

### ***HHS seeks to restrict use of short-term coverage***

The Department of Health and Human Services issued proposed regulations last month that seek to stabilize premium costs by restricting the use of short-term health insurance plans that do not comply with Affordable Care Act (ACA) standards and modifying the law's risk adjustment program for enrollees that only need part-year coverage.

According to the HHS Secretary, the proposed changes are intended to ensure the long-term viability of ACA Marketplaces by "closing a loophole" that allowed consumers to buy short-term coverage outside of the Marketplaces that is not subject to ACA rules on essential health benefits or discrimination so long as coverage lasted less than one year. Marketplace plans complained that consumers were relying on this cheaper, short-term coverage when they were in good health and jumping into more comprehensive Marketplace coverage once their health worsened, thereby skewing the risk pool.

Under the proposed rule, HHS seeks to correct this "moral hazard" by preventing insurers from offering short-term policies that last less than three months and longer allowing that coverage to be renewed. HHS stressed that these policies are intended only for consumers that truly have a temporary gap in coverage.

The regulations also tweak the ACA risk adjustment model so that payments to insurers reflect those consumers that enroll for only part of a year due to a major life change (such as changes in marital status or number of dependents). Starting in 2017, the model will also take into account data on prescription drug use by subscribers.

America's Health Insurance Plans stated that it supported the proposed changes as they would help improve "predictability and stability" for insurers.

### ***HHS gives states \$22 million to review premium hikes***

The Department of Health and Human Services (HHS) announced last week that it will provide state insurance regulators with an additional \$22 million to strengthen their ability to curtail unreasonable increases in health insurance premiums.



Under the Affordable Care Act (ACA), insurers are required to publicly justify any double-digit rate hikes. This data is provided to regulators in states with effective rate review processes (like Connecticut and Maryland), while HHS has assumed that role for other states like Texas (see Update for Week of August 29, 2011).

The additional \$22 million comes at a time when insurers are proposing dramatic increases in order to offset the end of the ACA's temporary risk corridor and reinsurance payments in 2017, which helped compensate insurers with exceptional claims history. Proposed rate hikes are averaging as high as 26.8 percent in the ACA Marketplace for Connecticut, while the Kaiser Family Foundation predicts actual premiums will increase by an average of 11 percent next year.

America's Health Insurance Plans (AHIP) has consistently opposed the expansion of rate review programs, insisting that they fail to address health care cost increases (particularly for prescription drugs) that are the underlying cause of higher premiums. They warn that stricter regulation of health insurance premiums could cause struggling insurers to leave ACA Marketplaces, as UnitedHealthcare and Humana did earlier this year (see Update for Week of April 18<sup>th</sup>).

However, a new study from The Commonwealth Fund showed that most other major insurers are planning to remain in ACA Marketplaces last year.

### ***Studies show wide range in premium hikes for lowest cost silver-tier coverage***

Recent analyses from the Robert Wood Johnson Foundation and Urban Institute show that premiums for the lowest priced silver-tier health plan averaged 8.3 percent nationwide from 2015 to 2016, even though premiums increased in all but five states over that time.

The studies revealed a wide range in rate hikes from state to state, with lowest cost silver-tier plans in the ACA Marketplace for Oklahoma experiencing a 41.8 percent average increase compared to a 12.1 percent average decrease in Indiana.

Overall, 29.1 percent of Americans live in states where premiums actually declined, while 26.3 percent resided in states with the highest increases (averaging at least 15 percent).

### ***CDC data shows significant increase in affordability of medical care***

The percentage of Americans that are forgoing medically necessary care due to cost has dramatically declined since the enactment of the Affordable Care Act (ACA), according to the latest data from the Centers for Disease Control and Prevention (CDC).

The agency's annual National Health Interview Survey found that only 4.5 percent of surveyed Americans could not afford needed medical care in 2015, compared to a peak of 6.9 percent in both 2009 and 2010. The report notes that before the ACA was signed into law in 2010, this figure has been steadily climbing from only 4.2 percent in 1998.

## **STATES**

### ***Class action lawsuit forces three more states to provide Medicaid coverage for all HCV patients***

A federal judge ordered the Washington Health Care Authority (HCA) late last month to cover drugs for Medicaid enrollees with the hepatitis C virus (HCV) regardless of the severity of an individual's liver condition.



HCA began limiting HCV coverage in February 2015 only to those with advanced liver disease, following the lead of Oregon and Illinois and at least 31 other states (see Update for Weeks of January 11<sup>th</sup> and 18<sup>th</sup>). The state Medicaid director justified the explicit rationing before Congress by insisting that HCA could not afford to pay three times the program's total pharmacy budget just for new HCV drugs that can cost Medicaid \$24,000-31,000 per month (see Update for Weeks of February 8<sup>th</sup> and 15<sup>th</sup>).

The Centers for Medicaid Services (CMS) warned all Medicaid agencies last fall that such rationing of care violates federal Medicaid law. Judge John Coughenour with the U.S. District Court for the Western District of Washington cited the CMS letter as part of his decision ordering HCA to lift their coverage restrictions.

The decision was part of a class action lawsuit brought against several state Medicaid programs by the Harvard Law School's Center for Health Law and Policy Innovation (see Update for Weeks of February 8<sup>th</sup> and 15<sup>th</sup>). It immediately forced states like Delaware and Florida to lift their Medicaid HCV coverage restrictions as well.

The Delaware Department of Health and Human Services will phase-in a new policy that will lift specific severity restrictions on July 1<sup>st</sup>, as well as the requirement that HCV patients not be abusing drugs. Other changes will be phased-in until the point where all HCV patients will be covered starting January 1, 2018.

The Florida Agency for Health Care Administration lifted all restrictions on June 1<sup>st</sup> except for the regulations requiring proof of abstinence from illicit drugs or alcohol. Managed care organizations had until June 17<sup>th</sup> to comply.

New York Medicaid had previously lifted their restrictions in April and seven New York insurers agreed to also halt the practice in the face of an investigation by that state's attorney general (see Update for Week of May 16<sup>th</sup>).

An advisory committee in Pennsylvania recommended similar changes last month, though state officials have yet to implement them.

### ***Two CO-OPs join insurers suing federal government over lost risk corridor payments***

Struggling non-profit health insurance cooperatives in Maryland and Illinois filed suit earlier this month against the Obama Administration demanding payment of risk corridor payments that they are due under the Affordable Care Act (ACA).

The ACA provided start-up loans to 23 Consumer Owned and Operated Plans (CO-OPs) before Congress rescinded the remaining funding as part of a bipartisan deficit reduction package (see Update for Weeks of December 24 and 31, 2012). However, at least 13 have failed since the Centers for Medicare and Medicaid Services (CMS) announced a shortfall in the ACA's risk corridor and reinsurance payments that were intended to compensate insurers with exceptional medical claims during the first three years of full ACA implementation. Insurers in and out of the Marketplaces have received only 12.6 percent of the amount they were due under the ACA (see Update for Week of November 30<sup>th</sup>).

Land of Lincoln Health in Illinois and Evergreen Health in Maryland were among two that survived despite incurring substantial losses as low premiums attracted a higher and sicker level of enrollment than anticipated.

Land of Lincoln received only \$550,000 in reinsurance payments for 2014 (instead of the \$4.5 million it was due) and is still owed nearly \$69 million for 2015. As a result, it has already pulled out of the small group market and will serve only individual consumers in 2017. However, it still meets the state's solvency requirements and does not expect to be liquidated.



Evergreen Health is suing for a different reason, as the risk corridor and reinsurance program is requiring it to pay \$22 million to dominant carrier CareFirst Blue Cross and Blue Shield, since CareFirst had a far sicker case-mix for 2015. Evergreen insists that such a payment would cause it to lose 26 percent of its premium revenue and become insolvent.

Four other private insurers including Highmark and Blue Cross and Blue Shield of North Carolina have filed similar lawsuits regarding risk corridor and reinsurance payments.

#### Alaska

##### ***Legislature approves reinsurance program for high-cost enrollees in individual market***

The House and Senate have approved a plan to stabilize health insurance premiums in the individual market through a reinsurance program for high-cost enrollees funded by an existing tax on all health insurers.

It is not yet clear if Governor Bill Walker (I) will sign the legislation (H.B. 374), which was prompted by Moda Health Plan's decision to exit the individual market for 2017, leaving Premera Blue Cross Blue Shield as the only remaining insurer and raising concerns of dramatic premium spikes (see Update for Week of January 25<sup>th</sup> and February 1<sup>st</sup>). If enacted, the measure will authorize the Department of Health and Social Services to seek the necessary Section 1332 waiver from the federal government.

#### Arizona

##### ***Governor signs biosimilar substitution bill into law***

Governor Doug Ducey (R) signed H.B. 2310 into law on May 24<sup>th</sup>, making Arizona one of 22 states to enact legislation regulating a pharmacist's ability to substitute biosimilar drugs for their brand-name reference product.

The bill largely follows model legislation supported by the Biotechnology Innovation Organization (BIO). It would only allow biosimilar substitution of biosimilar products deemed interchangeable by the FDA and only if the pharmacy informs the patient of the substitution and retains a record of the biosimilar dispensed. However, H.B. 2310 also requires that the pharmacist "notify the person presenting the prescription of the amount of price difference between the biological product prescribed and the interchangeable biological product, if: a) the medical practitioner does not indicate an intent to prevent substitution with an interchangeable biological product; and b) the transaction is not subject to third-party reimbursement."

#### Arkansas

##### ***Governor seeks permission to shift to state-based Marketplace that uses federal web portal***

Governor Asa Hutchinson (R) announced last week that he has requested federal permission to transition the State-Partnership Marketplace (SPM) created under the Affordable Care Act (ACA) to a State-based Marketplace on the Federal Platform (SBM-FP).

If approved, the switch would be effective for the 2017 open enrollment period and make Arkansas the fifth state to operate a state-based Marketplace that defaults to [www.healthcare.gov](http://www.healthcare.gov) (after Hawaii, Idaho, Nevada, and Oregon) Under the Governor's proposal, Arkansas would still have authority to certify individual Marketplace plans and assume plan management and consumer outreach function. However, it would rely on the federal web portal for eligibility and enrollment, including the federal call center.



The Governor insisted that the move would moderate future premium increases as it would decrease user fees charged to participating insurers.

### ***Insurance Commissioner to reject unjustified rate hikes by Marketplace insurers***

Insurance Commissioner Alan Kerr (R) announced last week that his office is likely to deny proposed premium hikes sought by four Marketplace insurers for 2017 because they lack “substantive justification”.

The requested rate hikes range from nearly 15 percent to 24 percent and were sought by plans offered by Arkansas Blue Cross and Blue Shield and QualChoice Life and Health. Pursuant to the Affordable Care Act (ACA), insurers are required to provide actuarial data publicly justifying any double-digit rate hike (see Update for Week of August 29, 2011). However, the commissioner insisted that the data offered by the insurers failed to show the rate hikes were needed due to medical inflation and would not be considered until such justification was provided.

### California

### ***Governor signs bill allowing undocumented residents to purchase Marketplace coverage***

Governor Jerry Brown (D) signed legislation last week that would make California the first in the nation to sell Marketplace coverage to undocumented residents.

Sponsored by Senator Ricardo Lara (D), the measure passed both chambers with bipartisan support. It would allow immigrants without legal status to purchase Covered California coverage, although they would remain ineligible for premium tax credits and cost-sharing subsidies offered under the Affordable Care Act (ACA).

Critics of S.B. 10 insist that without access to the ACA subsidies available to most Covered California subscribers, the measure is largely symbolic as most undocumented residents would be unable to afford full-price coverage. They also note that implementation would require federal approval of a Section 1332 waiver under the ACA, which may be politically unlikely during an election year.

Last year, California also became the first state in the nation to extend full Medi-Cal benefits to children of undocumented residents (see Update for Weeks of October 5<sup>th</sup> and 12<sup>th</sup>). That law became effective in May.

### ***Consumer protection bills move from Senate to House***

The Assembly Health Committee voted unanimously this week to advance legislation that would prevent health plans from imposing cost-sharing increases in the middle of a plan year.

S.B. 923, which passed the Senate in early May, now moves on to the Appropriations committee. It was sponsored by Senate Health Committee chair Ed Hernandez, MD, who authored other Senate-passed consumer protection legislation slated to be heard in Assembly committees this week, including S.B. 908 (protecting against unjustified premium increases) and the controversial S.B. 1010, which would increase transparency regarding drug price increases.

S.B. 1010 is similar to the first-in-the-nation bill enacted earlier this month in Vermont (see below) and those being considered in at least five other states. It would require drug manufacturers to provide purchasers and health plans a justification for increasing the wholesale acquisition cost (WAC) of the drug by more than ten percent or \$10,000 for brand-name drugs (within a 12 month period). The same justification would be required for price increases on generic drugs of at least \$100 per month or more than 25 percent.



Drug manufacturers would have to provide at least a 60-day notification of any such price increase (similar to existing state requirements on individual and small group insurers) and provide the justification within 30 days of that notification. The justification must include the previous year's marketing budget for the drug, the date and price of acquisition if the drug was not developed by the manufacturer, and a schedule of price increases for the previous five years.

If introducing a new drug to market, the manufacturer would have to provide notification to purchasers and plans with three days of Food and Drug Administration approval if the WAC is \$10,000 or more per year or per course of treatment.

A ballot measure this fall will let California voters decide whether to enact the *Drug Price Relief Act*, which would require the state to pay no more than U.S. Department of Veterans Affairs rates for prescription drugs (see Update for Week of April 18<sup>th</sup>).

#### Louisiana

#### ***Nearly 250,000 residents per week are enrolling in Medicaid expansion***

The Department of Health and Hospitals announced this week Louisiana is signing up nearly 250,000 residents per week into Medicaid since the June 1<sup>st</sup> start of enrollment in the Medicaid expansion that will become effective on July 1<sup>st</sup>.

New Governor John Bel Edwards (D) used an executive order to make Louisiana the 31<sup>st</sup> state to expand Medicaid pursuant to the Affordable Care Act (ACA) (see Update for Week of January 4<sup>th</sup>). However, it is the first to use existing food stamp eligibility data to find out if applicants are also eligible for Medicaid, because both programs rely on similar income thresholds.

State officials credit the food stamp eligibility data for the lion's share of the early enrollment in the Medicaid expansion.

#### Minnesota

#### ***BCBS pulls out of individual health insurance market for 2017***

Blue Cross and Blue Shield of Minnesota announced this week that it will no longer sell health plans to individuals and families starting next year, due to financial losses of more than \$500 million over the past three years.

The state's largest health insurer reported a \$265 million loss in the individual market just for 2015, with medical claims costs far exceeding their revenue from premiums. Their exit will impact more than 103,000 individual consumers, including roughly 20,000 currently enrolled in BCBS coverage through the MNSure Marketplace created pursuant to the Affordable Care Act (ACA).

A BCBS subsidiary called Blue Plus will remain in the individual market. Although it has only 13,000 subscribers, its entrance to MNSure in 2015 was credited with keeping the nation's lowest Marketplace premiums in line after the departure of its largest insurer, Preferred One (see Update for Week of September 29, 2014).

#### Missouri

#### ***Governor signs biosimilar substitution legislation***

Governor Jay Nixon (D) signed legislation last week that regulates the substitution of biosimilar drugs for their name-brand counterpart.

S.B. 175 had received only one dissenting vote in the House and Senate and will take effect in August. The bill follows model legislation supported by the Biotechnology Innovation Organization (BIO)



that has been enacted in more than 20 other states. It allows retail pharmacies to substitute interchangeable biosimilar drugs under certain circumstances.

#### Ohio

##### ***Coordinated Health Mutual becomes 13<sup>th</sup> CO-OP to fail***

Lt. Governor Mary Taylor (R) has been appointed by a state court as the receiver for Coordinated Health Mutual, Inc. following the Department of Insurance (ODI) request last month to liquidate the Consumer Owned and Operated Plan (CO-OP) that was created with Affordable Care Act (ACA) loans.

Coordinated Health Mutual becomes the 13<sup>th</sup> of 23 CO-OPs to fail since the federal Centers for Medicare and Medicaid Services announced last fall that all insurers would receive only 12.6 percent of the ACA reinsurance payments they were due for exceptional medical claims (see Update for Week of November 30<sup>th</sup>). At least two of the remaining CO-OPs have filed suit against the Obama Administration relating to those funds (see above).

Coordinated Health Mutual would have ended the year with a \$20 million loss had it been allowed to continue operations. Its liquidation will impact nearly 22,000 consumers covered under its InHealth Mutual brand (or nine percent of all Marketplace enrollees). ODI will wind-down operations and allow consumers to switch to other Marketplace coverage within 60 days.

#### Oklahoma

##### ***Medicaid expansion on hold after budget deal negates 25 percent reimbursement cut***

The legislature passed a budget plan on May 27<sup>th</sup> that filled a projected \$1.3 billion deficit without a 25 percent proposed cut in Medicaid provider reimbursement rates that would have been the largest in state history.

The Oklahoma Health Care Authority had proposed the dramatic cuts in April but then quickly released draft legislation that would replace the cuts with a federally-approved alternative to the Medicaid expansion under the Affordable Care Act (ACA) (see Update for Week of April 18<sup>th</sup>). The Authority's Medicaid Rebalancing Act avoided the politically-toxic term "Medicaid expansion" but would have used ACA funds to provide premium assistance so that those made newly-eligible for Medicaid could purchase private coverage, similar to models the Obama Administration has approved for seven other states.

The plan actually attracted some support among Republican lawmakers previously opposed to Medicaid expansion, including Governor Mary Fallin (R) who sought to the state portion paid through a new consumption tax on cigarettes. However, the budget deal ended deliberations on any cigarette tax or Medicaid expansion for the near term.

#### Oregon

##### ***ACA Marketplace will continue to rely on federal web portal***

The Department of Consumer and Business Services announced last month that Oregon will continue to rely upon the federal web portal for consumers in the state-based Marketplace (SBM).

Oregon is one of four states (Hawaii, Idaho, and Nevada) that created their own Marketplace but elected to use [www.healthcare.gov](http://www.healthcare.gov). Cover Oregon had tried and failed to design and operate its own portal but gave up in 2014 after technological impediments prevented any online functionality during the inaugural open enrollment period (see Update for Week of June 2, 2014).

State officials noted that importing the web portal from another states (as Maryland did from Connecticut) would cost Oregon \$3 million more per year than the \$31 million price tag for remaining with the federal web portal.



### South Carolina

#### ***New bill would ensure availability of non-profit premium assistance in ACA Marketplace***

Rep. Tommy Stringer (R) introduced legislation last month that would allow individuals enrolled in qualified health plans offered in the Affordable Care Act (ACA) Marketplace to receive premium assistance from non-profit, charitable organizations like Patient Services Inc. (PSI). The measure was referred to the House Committee on Labor, Commerce, and Industry.

H.5317 would correct an omission in federal regulations that required Marketplace insurers accept third-party premium assistance from federal and state health care programs, but remained silent on non-profit assistance (see Update for Week of June 2, 2014). Since that interim final rule in 2014, insurers in at least 38 states have used this discretion to refuse such assistance.

A Congressional bill that would ensure the availability of premium assistance from non-profits now has at least 77 cosponsors from both parties (see Update for Weeks of October 5 and 12, 2015). Lawmakers in states like Florida are considering similar state remedies for next session.

### Vermont

#### ***Governor signs drug pricing transparency bill into law***

Governor Peter Shumlin (D) signed S. 216 into law earlier this month, making Vermont the first state to require that pharmaceutical manufacturers submit justifications for increasing prices on certain drugs.

The new law gives the Green Mountain Care Board, in collaboration with the Department of Vermont Health Access (VHA), the authority to identify 15 drugs on which the state spends significant health care dollars and “for which the wholesale acquisition cost [WAC] has increased by 50 percent or more over the past five years or by 15 percent or more over the past 12 months.” The list will be posted on the Board’s website (without identifying an individual drug or manufacturer) and used by the Attorney General to require the manufacturer of each drug to provide data showing the increase to be “understandable and appropriate”.

In order to meet this threshold, the data must identify all factors contributing to the WAC increase, the percentage of the total increase attributable to each factor, and an explanation of each factor’s contribution.

The Attorney General and VHA will report to the legislature on the information it received from manufacturers no later than December 1<sup>st</sup> of every year. Manufacturers can be fined up to \$10,000 for each failure to submit the required information.

Similar drug pricing transparency legislation is being considered in at least six other states this session including California (see above), New York, Pennsylvania, and Texas while drug cost containment measures are already in place in at least 25 states.

### Virginia

#### ***Marketplace insurer drops bronze tier coverage for 2017***

A subsidiary of CareFirst Blue Cross and Blue Shield announced last month that it would no longer include bronze tier plans among the selections it provides to Marketplace consumers.

Bronze plans are the least generous option for consumers, covering only 60 percent of medical costs on average. They typically offer the lowest premiums but highest deductibles.



During the 2016 open enrollment period, only 23 percent of Marketplace consumers nationwide enrolled in bronze coverage, with the majority (68 percent) electing the silver tier coverage to which the Affordable Care Act (ACA) premium and cost-sharing subsidies are tied. According to the Robert Wood Johnson Foundation, enrollment in bronze plans increased by only one percent from 2015 to 2016, compared to nearly three percent for silver plan coverage.

Group Hospitalization and Medical Services made the decision to eliminate bronze coverage in the Virginia Marketplace for 2017, but has yet to do so for the other Marketplaces in which it participates.